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12-1-1976

## Litigation: Areas of Dispute Student Symposium - A Study of Medical Malpractice in Texas.

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### Recommended Citation

Caroline W. Jackson, *Litigation: Areas of Dispute Student Symposium - A Study of Medical Malpractice in Texas.*, 7 ST. MARY'S L.J. (1976).

Available at: <https://commons.stmarytx.edu/thestmaryslawjournal/vol7/iss4/5>

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## LITIGATION: AREAS OF DISPUTE

The medical malpractice "crisis" is a multi-faceted problem. This paper will examine some of the areas of malpractice litigation to clarify some of the issues, identify some of the trends, and suggest some direction for the future.

The initial consideration in any medical malpractice litigation is whether or not there existed between the plaintiff and the defendant, a physician-patient relationship at the time of the alleged negligent act.<sup>1</sup> Despite some suggestions to the contrary,<sup>2</sup> a physician has no affirmative duty to undertake treatment of all who request his services.<sup>3</sup> Generally, if a physician has been employed by an employer to examine an employee, the physician has no other duty to the employee than to not injure him.<sup>4</sup> Finally, if a patient discharges his physician, the physician owes no further duty to him;<sup>5</sup> however, the physician may not refuse to continue the physician-patient relationship unless the patient either agrees or no longer requires the services of a physician or has been given sufficient notice to employ another physician.<sup>6</sup>

### ASSAULT AND BATTERY

Prior to the general acceptance of negligence as the most appropriate theory of recovery in medical malpractice suits, courts permitted recovery for unauthorized medical treatment based on a theory of assault and battery.<sup>7</sup> The foundation for this recovery was the belief that every individual has a

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1. Hurley v. Eddingfield, 59 N.E. 1058 (Ind. 1901); J. PERDUE, *THE LAW OF TEXAS MEDICAL MALPRACTICE* § 1.00, at 2 (1975). See generally McCoid, *The Care Required of Medical Practitioners*, 12 VAND. L. REV. 549, 553-57 (1959).

2. See Letourneau, *Physicians' and Hospitals' Liability: Negligent Acts Committed in the Hospital*, LEGAL MED. ANN.: 1969, at 61, 70; McCoid, *The Care Required of Medical Practitioners*, 12 VAND. L. REV. 549, 553 n.20 (1959).

3. Childs v. Weis, 440 S.W.2d 104, 107 (Tex. Civ. App.—Dallas 1969, no writ); Urrutia v. Patino, 297 S.W. 512, 516 (Tex. Civ. App.—San Antonio 1927, no writ).

4. Lotspeich v. Chance Vought Aircraft, 369 S.W.2d 705, 710 (Tex. Civ. App.—Dallas 1963, writ ref'd n.r.e.) (pre-employment physical examination). But see Johnson v. Borland, 26 N.W.2d 755 (Mich. 1947) (physician called by third person to treat a patient).

5. Lawson v. Conaway, 16 S.E. 564, 566 (W. Va. 1892).

6. Becker v. Janinski, 15 N.Y.S. 675, 676 (N.Y. Com. Pl. 1891); accord, Lee v. Moore, 162 S.W. 437, 440 (Tex. Civ. App.—Dallas 1913), rev'd on other grounds, 109 Tex. 391, 211 S.W. 214 (1919).

7. Pratt v. Davis, 79 N.E. 562, 564 (Ill. 1906); Mohr v. Williams, 104 N.W. 12, 14-15 (Minn. 1905); Schloendorff v. Society of New York Hosp., 105 N.E. 92, 93 (N.Y. 1914), overruled on other grounds, Bing v. Thunig, 163 N.Y.S.2d 1 (1957); Rolater v. Strain, 137 P. 96, 97 (Okla. 1913). See generally McCoid, *A Reappraisal of Liability for Unauthorized Medical Treatment*, 41 MINN. L. REV. 381 (1957).

right to the inviolability of his person, and a physician would be liable for any unauthorized violation of that right. Liability attached despite the fact that the physician performed the treatment with due care and that the treatment was beneficial to the patient. An exception to this rule was recognized in an emergency situation whereby consent to the treatment was implied.<sup>8</sup>

Texas gave early recognition to battery as a theory of recovery.<sup>9</sup> Recently, however, battery has become involved with the question of informed consent, particularly when there are allegations that the defendant failed to disclose information concerning risks involved in a medical procedure.<sup>10</sup> Although there are courts which hold that an action for failure to disclose a material risk is an action for battery or a combination of both battery and negligence,<sup>11</sup> the majority, including Texas, agree that the action is basically one for negligence.<sup>12</sup> The battery theory is still viable, though, in cases where there is a complete lack of consent<sup>13</sup> to treatment or where a different or unnecessary operation is performed.<sup>14</sup>

#### CONTRACT TO CURE

Prior to the emergence of negligence as the basic medical malpractice theory of recovery, many malpractice cases were decided on grounds of

8. McCoid, *A Reappraisal of Liability for Unauthorized Medical Treatment*, 41 MINN. L. REV. 381, 392 (1957).

9. *Moss v. Rishworth*, 222 S.W. 225, 226-27 (Tex. Comm'n App. 1920, holding approved).

10. See Capron, *Informed Consent in Catastrophic Disease Research and Treatment*, 123 U. PA. L. REV. 340, 403-23 (1974). The author states that "[t]he reasons for this difficulty are readily apparent. While a medical intervention without consent is a battery, many courts have declined to find that the absence of information invalidated the consent which had been obtained and have decided instead that it indicated a lapse in professional behavior—a part of the physician's obligation—to be judged by malpractice standards . . . ." *Id.* at 404.

11. *E.g.*, *Abril v. Syntex Laboratories, Inc.*, 364 N.Y.S.2d 281, 283 (Sup. Ct. 1975) (assault); *Barnette v. Potenza*, 359 N.Y.S.2d 432, 436 (Sup. Ct. 1974) (assault); *Congrove v. Holmes*, 308 N.E.2d 765, 770 (C.P. Ross County, Ohio 1973) (both negligence and assault and battery); *Gray v. Grunnagle*, 223 A.2d 663, 668-69 (Pa. 1966) (assault).

12. *Wilson v. Scott*, 412 S.W.2d 299, 302 (Tex. 1967). The court held that the "traditional elements of assault and battery, unlawful use of violence upon another and intent to injure, are absent in most malpractice cases based upon a doctor's failure to make sufficient disclosure." *Id.* at 302; *accord, e.g.*, *Cobbs v. Grant*, 104 Cal. Rptr. 505, 511 (1972); *Perin v. Hayne*, 210 N.W.2d 609, 618 (Iowa 1973); *Wilkinson v. Vesey*, 295 A.2d 676, 686 (R.I. 1972); *Miller v. Kennedy*, 522 P.2d 852, 860 (Wash. Ct. App. 1974).

13. *Pearl v. Lesnick*, 278 N.Y.S.2d 237, 238 (1967); *Hively v. Higgs*, 253 P. 363, 364-65 (Ore. 1927); *Gravis v. Physicians & Surgeons Hosp.*, 427 S.W.2d 310, 311 (Tex. 1968).

14. *Pedesky v. Bleiberg*, 59 Cal. Rptr. 294 (Ct. App. 1967) (different operation); *Bang v. Charles T. Miller Hosp.*, 88 N.W.2d 186 (Minn. 1958) (different operation); *White v. Hirshfield*, 236 P. 406 (Okla. 1925) (unnecessary operation).

either breach of an express or implied contract to cure.<sup>15</sup> By 1970 only five states still recognized implied contracts to cure,<sup>16</sup> but the majority continue to recognize the existence of express contracts and liability resulting from the breach thereof.<sup>17</sup>

There are two theories concerning the facts which must be proved in order to establish the existence of an express contract to cure.<sup>18</sup> The first theory and the one supported by the weight of authority is that the plaintiff must prove explicit words of guarantee and subsequent breach in order to recover.<sup>19</sup> A second theory, applied by only a few courts, requires proof of separate consideration for the contract itself before recovery will be allowed.<sup>20</sup> This latter rule has the effect of virtually eliminating contract actions in malpractice suits since in very few cases can it be proved that the contract was supported by consideration separate and apart from the fee paid to a physician for rendering services. Under either theory the evidentiary requirements are greatly relaxed since it is necessary only to show the existence of the contract and its breach.<sup>21</sup> The fact that the physician acted with due care is of no consequence in a contract action; therefore, expert testimony is not required.<sup>22</sup> The liability for breach of contract is absolute

15. *E.g.*, *Carpenter v. Walker*, 54 So. 60, 61 (Ala. 1910); *Crawford v. Duncan*, 215 P. 573, 574 (Cal. App. 1923); *Sherlag v. Kelley*, 86 N.E. 293, 294 (Mass. 1908); *Brooks v. Herd*, 257 P. 238, 239 (Wash. 1927). *See generally* Miller, *The Contractual Liability of Physicians and Surgeons*, 1953 WASH. U.L.Q. 413; Tierney, *Contractual Aspects of Malpractice*, 19 WAYNE L. REV. 1457 (1973); Comment, *Express Contracts to Cure: The Nature of Contractual Malpractice*, 50 IND. L.J. 361 (1975); Comment, *Establishing the Contractual Liability of Physicians*, 7 U.C.D.L. REV. 84 (1974); Comment, *The Implied Contract Theory of Malpractice Recovery*, 6 WILLAMETTE L.J. 275 (1970); Note, *Contractual Liability in Medical Malpractice—Sullivan v. O'Connor*, 24 DE PAUL L. REV. 212 (1974); Note, *Torts—Medical Malpractice—Express Warranty of Particular Results of an Operation*, 41 TENN. L. REV. 964 (1974).

16. Comment, *The Implied Contract Theory of Malpractice Recovery*, 6 WILLAMETTE L.J. 275 (1970). The five states are Alabama, Florida, Georgia, Illinois, and Louisiana. *Id.* at 275 n.3.

17. *E.g.*, *Kozan v. Comstock*, 270 F.2d 839, 843-45 (5th Cir. 1959); *Noel v. Proud*, 367 P.2d 61, 66 (Kan. 1962); *Stewart v. Rudner*, 84 N.W.2d 816, 823 (Mich. 1957); *Cloutier v. Kasheta*, 197 A.2d 627, 628-29 (N.H. 1964); *Robins v. Finestone*, 127 N.E.2d 330, 331 (N.Y. 1955).

18. *See* Tierney, *Contractual Aspects of Malpractice*, 19 WAYNE L. REV. 1457, 1463-73 (1973).

19. *Hawkins v. McGee*, 146 A. 641, 643 (N.H. 1929); Tierney, *Contractual Aspects of Malpractice*, 19 WAYNE L. REV. 1457, 1463 (1973); Note, *Contractual Liability in Medical Malpractice—Sullivan v. O'Connor*, 24 DE PAUL L. REV. 212, 214 (1974).

20. *Rogala v. Silva*, 305 N.E.2d 571, 573 (Ill. Ct. App. 1973); *Gault v. Sideman*, 191 N.E.2d 436, 441 (Ill. Ct. App. 1963); *Wilson v. Blair*, 211 P. 289, 293 (Mont. 1922), *overruled on other grounds*, *A.T. Klemens & Son v. Reber Plumbing & Heating Co.*, 360 P.2d 1005 (Mont. 1961). This theory has been criticized. Tierney, *Contractual Aspects of Malpractice*, 19 WAYNE L. REV. 1457, 1469 & nn. 34 & 37 (1973).

21. *Weeks v. Heinrich*, 447 S.W.2d 688, 695 (Tex. Civ. App.—Corpus Christi 1969, writ ref'd n.r.e.). *See also* Comment, *Establishing the Contractual Liability of Physicians*, 7 U.C.D.L. REV. 84, 85 (1974).

22. *Guilmet v. Campbell*, 188 N.W.2d 601, 606 (Mich. 1971). *See also* J. PERDUE, *THE LAW OF TEXAS MEDICAL MALPRACTICE* § 1.07, at 14 and § 8.05, at 185 (1975).

once the contract and breach have been established.<sup>23</sup>

In considering recovery for breach of an express contract, it is first necessary to determine whether or not a contract has, in fact, been made.<sup>24</sup> Where the contract is for the performance of specific procedures and those procedures are not performed, clearly the contract has been breached.<sup>25</sup> Where it is alleged, however, that a contract for specific results has been made, problems arise in distinguishing between express contracts and the physician's therapeutic reassurances.<sup>26</sup> It is natural for a physician to want to relieve an uneasy patient's anxiety by reassurances and optimistic predictions of the outcome of medical procedures.<sup>27</sup> If a physician goes too far and makes specific promises, however, he is subjecting himself to the possibility of a law suit by a disappointed patient if the procedure fails to produce the promised result.<sup>28</sup>

In addition to the fact that contract actions do not require expert testimony, plaintiffs who bring malpractice suits based on breach of contract enjoy the benefit of a longer limitations period in most jurisdictions.<sup>29</sup> This

23. Comment, *Establishing the Contractual Liability of Physicians*, 7 U.C.D.L. REV. 84, 89-90 (1974).

24. See *Helms v. Day*, 215 S.W.2d 356, 358 (Tex. Civ. App.—Fort Worth 1948, writ dismissed); *Turner v. Stoker*, 289 S.W. 190, 194 (Tex. Civ. App.—Eastland 1926, writ refused); *Lakeside Sanitarium v. Dickens*, 259 S.W. 1110, 1111 (Tex. Civ. App.—Austin 1924, no writ); Note, *Contractual Liability in Medical Malpractice—Sullivan v. O'Connor*, 24 DE PAUL L. REV. 212, 214-17 (1974).

25. See, e.g., *Foran v. Carangelo*, 216 A.2d 638 (Conn. 1966); *Brooks v. Robinson*, 163 So. 2d 186 (La. 1964); *Stewart v. Rudner*, 84 N.W.2d 816 (Mich. 1957). See also Comment, *Establishing the Contractual Liability of Physicians*, 7 U.C.D.L. REV. 84, 94-96 (1974).

26. Generally, once it has been determined that the allegations of the plaintiff's petition are sufficient to support a cause of action for breach of contract, the ultimate determination of whether or not there was a contract is for the jury. *Hawkins v. McGee*, 146 A. 641, 643 (N.H. 1929); *Levine v. Carrell*, 68 S.W.2d 259, 262 (Tex. Civ. App.—El Paso 1934, no writ); see *Noel v. Proud*, 367 P.2d 61, 67 (Kan. 1961). But see *Guilmet v. Campbell*, 188 N.W.2d 601, 606 (Mich. 1971) (whether or not verbal assurances constituted contract was question for jury). In some instances the use of the word "cure" has proved sufficient to get the case to trial. *Robins v. Finestone*, 127 N.E.2d 330, 331 (N.Y. 1955).

27. See Comment, *Establishing the Contractual Liability of Physicians*, 7 U.C.D.L. REV. 84, 92 n.28 (1974) (discussion of therapeutic reassurances).

28. *Id.* at 92. See also Note, *Contractual Liability in Medical Malpractice—Sullivan v. O'Connor*, 24 DE PAUL L. REV. 212, 216 (1974). It seems probable that this is the way most malpractice contract cases would arise since it is generally recognized in the medical profession that no reputable doctor would expressly guarantee a cure. Tierney, *Contractual Aspects of Malpractice*, 19 WAYNE L. REV., 1457, 1462 (1973). See also *Safian v. Aetna Life Ins. Co.*, 24 N.Y.S.2d 92, 95 (App. Div. 1940); Miller, *The Contractual Liability of Physicians and Surgeons*, 1953 WASH. U.L.Q. 413, 418 (1953).

29. For discussion and listing of the statutes of limitations in various jurisdictions see 1 D. LOUISELL & H. WILLIAMS, *MEDICAL MALPRACTICE* ¶¶ 13.14-13.64, at 385-416.17 (1973, Supp. 1975); Note, *Medical Malpractice: A Survey of Statutes of Limitations*, 3 SUFFOLK U.L. REV. 597 (1969). Some states have solved part of

factor was important in malpractice suits before courts had generally accepted the discovery rule of limitations in tort actions.<sup>30</sup> Although the discovery rule has helped diminish the importance of a contract theory of recovery, an action based on breach of contract could still prove to be a valuable plaintiff's tool affording some measure of relief in situations where a negligence action will not lie.<sup>31</sup>

If at all possible, most plaintiffs will plead a cause of action in negligence since the measure of damages recoverable is generally much higher than in contract actions.<sup>32</sup> In a negligence action, the plaintiff may recover an amount sufficient to return him to his original condition, including compensation for pain and suffering resulting from the medical injury.<sup>33</sup> In such a contract action, damages are usually the value of the expected performance and such other expenses as might reasonably have been in the contemplation of the parties at the time the contract was made.<sup>34</sup> As a rule, the recovery does not include pain and suffering, although there are some anomalous cases which have allowed an award of damages for pain and suffering in a breach of contract suit.<sup>35</sup>

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this problem by adopting the same statute of limitations for both tort and contract actions. Note, *Contractual Liability in Medical Malpractice—Sullivan v. O'Connor*, 24 DE PAUL L. REV. 212, 220-21 & n.35 (1974).

30. As of 1973, 36 jurisdictions have accepted the discovery rule or recognized an extended statute of limitations for fraudulent concealment of an injury. Deitz, Baird, & Berul, *The Medical Malpractice Legal System*, MEDICAL MALPRACTICE: REPORT OF THE SECRETARY'S COMMISSION ON MEDICAL MALPRACTICE, APPENDIX, Pub. No. (OS) 73-89, at 87, 134 (1973) [hereinafter cited as MALPRACTICE COMMISSION REPORT, APP.]; see Comment, *The Implied Contract Theory of Malpractice Recovery*, 6 WILLAMETTE L.J. 275, 280-83 (1970).

31. It seems indisputable that a plaintiff should be allowed to recover at least his out-of-pocket expenses in cases where the physician has not been negligent in his treatment but the expressly guaranteed results did not occur. In such cases, the only remedy available would be one based on breach of contract. Comment, *Establishing the Contractual Liability of Physicians*, 7 U.C.D.L. REV. 84, 93, 109-12 (1974). *Contra*, Comment, *The Implied Contract Theory of Malpractice Recovery*, 6 WILLAMETTE L.J. 275 (1970). The author argues that a contract theory of recovery defeats the legislative intent of shorter statutes of limitations for malpractice actions and provides a subterfuge for plaintiffs who could not prove a tort case for malpractice or who have not been diligent in enforcing their rights. *Id.* at 284-85.

32. Comment, *The Implied Contract Theory of Malpractice Recovery*, 6 WILLAMETTE L.J. 275, 283-84 (1970). See generally Annot., 43 A.L.R.3d 1221 (1972).

33. Barnhoff v. Aldridge, 38 S.W.2d 1029, 1030 (Mo. 1931); Robins v. Finestone, 127 N.E.2d 330, 332 (N.Y. 1955); Colvin v. Smith, 92 N.Y.S.2d 794, 795 (App. Div. 1949). See generally C. McCORMICK, DAMAGES 309-23 (1935).

34. Robins v. Finestone, 127 N.E.2d 330, 332 (N.Y. 1955); Hertgen v. Weintraub, 215 N.Y.S.2d 379, 381 (Sup. Ct. 1961); Lakeside Sanitarium v. Dickens, 259 S.W. 1110, 1111 (Tex. Civ. App.—Austin 1924, no writ). See generally 5 A. CORBIN, CONTRACTS § 1002 (1964).

35. Stewart v. Rudner, 84 N.W.2d 816, 824 (Mich. 1957). Compare 11 S. WILLISTON, THE LAW OF CONTRACTS § 1341, at 214 (3d ed. 1968) with Sullivan v. O'Connor, 296 N.E.2d 183, 189 (Mass. 1973). Although the Stewart case awarded damages for pain and suffering without a showing of "reckless" or "wanton" conduct,

A major problem with a breach of contract suit for malpractice from the physician's viewpoint is that malpractice insurance generally does not cover contract damages.<sup>36</sup> Obviously, then, one large recovery for breach of a contract could financially ruin a physician and probably terminate his practice, even though the contract was entered into inadvertently. This rather horrifying prospect is magnified by those cases which have also awarded damages for pain and suffering.<sup>37</sup>

One logical response to the possibility of breach of contract liability is a requirement by the physician that each patient sign an elaborate consent form detailing all possible risks and disclaiming warranty of any sort.<sup>38</sup> Minimum disclosure standards have been advocated in response to informed consent problems, particularly with regard to more radical treatments for catastrophic diseases involving a high degree of risk.<sup>39</sup> Requiring a patient to sign a detailed consent and disclaimer of warranty prior to any sort of treatment, however, not only appears to be an adhesion contract<sup>40</sup> but also effectively eliminates a physician's therapeutic privilege not to disclose, and vitiates any therapeutic reassurances he might wish to make to the patient.<sup>41</sup> A better approach is the one recommended by the Medical Professional Liability Study Commission in Texas which would allow recovery for breach of a contract to cure only when the parties have entered into a written and notarized contract.<sup>42</sup> This has the advantage of allowing the parties to contract freely if they so desire without any coercion on the part of the physician or the patient's assertion of contract based on expansive promises made by the physician.<sup>43</sup>

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there is recognized in the *Restatement* an exception to the general rule of no recovery for pain and suffering in a contract action when it can be shown that breach of the contract was wanton or reckless. RESTATEMENT OF CONTRACTS § 341 (1932).

36. *McGee v. United States Fidelity & Guar. Co.*, 53 F.2d 953, 956 (1st Cir. 1931); *Safian v. Aetna Life Ins. Co.*, 24 N.Y.S.2d 92, 94-95 (App. Div. 1940).

37. See Note, *Contractual Liability in Medical Malpractice—Sullivan v. O'Connor*, 24 DE PAUL L. REV. 212, 224-26 (1974).

38. For a discussion of this proposition see Tierney, *Contractual Aspects of Malpractice*, 19 WAYNE L. REV. 1457, 1475-80 (1973).

39. See Capron, *Informed Consent in Catastrophic Disease Research and Treatment*, 123 U. PA. L. REV. 340, 369-71 (1974); Comment, *Restructuring Informed Consent: Legal Therapy for the Doctor-Patient Relationship*, 79 YALE L.J. 1533, 1561-64 (1970). The federal government has set out regulations governing HEW grants and contracts supporting research involving human subjects which require the informed consent of the subjects and which set forth the basic elements of information necessary for such consent. DHEW Reg. for the Protection of Human Subjects, 45 C.F.R. §§ 46.101(a), (b)(3), 46.103(c) (1975).

40. *Tunkl v. Regents of the Univ. of Cal.*, 32 Cal. Rptr. 33, 34-38 (1963).

41. Tierney, *Contractual Aspects of Malpractice*, 19 WAYNE L. REV. 1457, 1478-79 (1973); Comment, *Establishing the Contractual Liability of Physicians*, 7 U.C.D.L. REV. 84, 91-92 (1974).

42. Keeton, *Introduction: Medical Malpractice in Texas*, 7 ST. MARY'S L.J. 733, 734 (1976).

43. There are very few cases in Texas dealing with contracts to cure although breach

## STANDARD OF CARE IN GENERAL

Courts and lawyers, as they began to recognize that actions for medical malpractice were more appropriately grounded in negligence as a theory of recovery than in battery or contract, were also forced to struggle with the question of the appropriate standard of care by which to judge the actions of the defendants.<sup>44</sup> It was never seriously questioned that the standard of care to be applied in medical malpractice actions deserved special consideration and treatment by the courts due to the highly technical nature of the issues involved.<sup>45</sup> There is general agreement that expert testimony is required in most cases to establish the standard of care;<sup>46</sup> the jury is then permitted to determine whether or not the defendant-physician deviated from that standard.<sup>47</sup>

The negligence of physicians can be divided into three main categories:<sup>48</sup>

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of contract is recognized as a theory of recovery in the medical malpractice area. If a physician expressly agrees to remedy a particular condition and fails to do so, he may be liable for breach of contract. *Levine v. Carrell*, 68 S.W.2d 259, 262 (Tex. Civ. App.—El Paso 1934, no writ). A physician is not an insurer, however, and lacking such a specific agreement, he is held to possess only a reasonable degree of skill and to exercise that skill with reasonable care and diligence. *Graham v. Gautier*, 21 Tex. 111, 120 (1858); *Helms v. Day*, 215 S.W.2d 356, 358 (Tex. Civ. App.—Fort Worth 1948, writ *dism'd*).

44. McCoid, *The Care Required of Medical Practitioners*, 12 VAND. L. REV. 549, 549-53 (1959). Numerous publications contain discussions of the standard of care for medical malpractice suits. See J. PERDUE, *THE LAW OF TEXAS MEDICAL MALPRACTICE* §§ 2.00-2.05, at 21-40; W. PROSSER, *HANDBOOK OF THE LAW OF TORTS* § 32, at 161-66 (4th ed. 1971); Charfoos, *Helling: The Law of Medical Malpractice Rewritten*, 2 OHIO NORTH. L. REV. 692, 693 (1975); Ellin, *The Law of Medical Malpractice in Maryland: A Plaintiff's Dilemma*, 3 U. BALT. L. REV. 207 (1975); King & Coe, *The Wisdom of the Strict Locality Rule*, 3 U. BALT. L. REV. 221 (1975); Waltz, *The Rise and Gradual Fall of the Locality Rule in Medical Malpractice Litigation*, 18 DE PAUL L. REV. 408, 409 (1969); Note, *An Evaluation of Changes in the Medical Standard of Care*, 23 VAND. L. REV. 729, 730 (1970).

45. See *McHugh v. Audet*, 72 F. Supp. 394, 399 (M.D. Pa. 1947); *Loudon v. Scott*, 194 P. 488, 491 (Mont. 1920).

46. *E.g.*, *Bowles v. Bourdon*, 148 Tex. 1, 5, 219 S.W.2d 779, 782 (1949). See generally J. PERDUE, *THE LAW OF TEXAS MEDICAL MALPRACTICE* §§ 6.00-6.03, at 108-25 (1975).

47. See F. HARPER & F. JAMES, *TORTS* § 17.1, at 968-69 (1956); J. PERDUE, *THE LAW OF TEXAS MEDICAL MALPRACTICE* § 6.05 B, at 135-36 (1975).

48. Keeton, *Annual Survey of the Law: Torts*, 23 SW. L.J. 1, 5 (1969). See also J. PERDUE, *THE LAW OF TEXAS MEDICAL MALPRACTICE* §§ 3.00-3.06, at 41-66 (1975).

It should be remembered, too, that in any situation in which a physician may be personally liable for negligence there is also the possibility that he may be vicariously liable for the negligence of those with whom he works. Probably because of the doctrines of charitable and governmental immunities, plaintiffs urged acceptance of vicarious liability theories as to a physician for the negligence of operating room personnel. This use of the "captain of the ship" or "borrowed servant doctrine" seems to have gained general recognition in Texas in the past 11 years to the extent that defendant physicians have simply conceded liability if operating room personnel are found negligent. Compare *Webb v. Jorns*, 488 S.W.2d 407, 411 (Tex. 1972) with *McKinney v. Tromly*, 386 S.W.2d 564, 565-66 (Tex. Civ. App.—Tyler 1964, writ *ref'd*



(1) failure to make a correct diagnosis,<sup>49</sup> (2) negligent administration of surgical procedures or treatment,<sup>50</sup> and (3) failure to consult a specialist.<sup>51</sup> In the first instance mere improper diagnosis without more is not sufficient to allow recovery. The patient must show that he was harmed either by delay in the administration of proper treatment or by the administration of improper treatment.<sup>52</sup> In the third situation, it should be noted that a physician is not required to consult a specialist in all cases but only when it becomes clear or should have become clear to the treating physician that he does not have the necessary skills or knowledge to deal with the patient's problem.<sup>53</sup> Here, too, the patient must show proximate cause by showing

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n.r.e.). The vicarious liability of a physician may include liability for the acts of his employees. *Porter v. Puryear*, 258 S.W.2d 182, 188 (Tex. Civ. App.—Amarillo), *aff'd*, 153 Tex. 82, 262 S.W.2d 933 (1953), *rev'd on other grounds on rehearing*, 153 Tex. 92, 264 S.W.2d 689 (1954). It may also include liability for the negligent selection of a substitute or a specialist to treat the plaintiff. See *Sendjar v. Gonzalez*, 520 S.W.2d 478, 481 (Tex. Civ. App.—San Antonio 1975, no writ); *Ross v. Sher*, 483 S.W.2d 297, 301 (Tex. Civ. App.—Houston [14th Dist.] 1972, writ ref'd n.r.e.).

Relaxation of governmental immunities under the provisions of the Texas Tort Claims Act, TEX. REV. CIV. STAT. ANN. art. 6252-19 (1970), and the abolition of charitable immunities has caused the area of vicarious liability for medical malpractice to be in a state of flux. *Howle v. Camp Amon Carter*, 470 S.W.2d 629, 630 (Tex. 1971). Plaintiffs are now suing hospitals for negligent selection of hospital staff or for failure to supervise the staff and physicians privileged to use the facilities. Compare *Penn Tanker Co. v. United States*, 310 F. Supp. 613, 618 (S.D. Tex. 1970) with *Darling v. Charleston Community Memorial Hosp.*, 211 N.E.2d 253, 258 (Ill. 1965). Courts are no longer holding physicians liable for the negligence of operating room personnel in all instances. *Ramone v. Mani*, — S.W.2d — (Tex. Civ. App.—Eastland 1975), *on motion for rehearing*, 13 TLWD 3 (1976) (not yet reported). Furthermore, both the hospital and the physician have been held liable for the negligence of a nurse in failing to make a proper sponge count on the theory that the nurse was under the joint control of both. *Worley Hosp., Inc. v. Caldwell*, 529 S.W.2d 639, 641-43 (Tex. Civ. App.—Amarillo 1975, no writ). These publications discuss the problems of vicarious liability and immunities. J. PERDUE, *THE LAW OF TEXAS MEDICAL MALPRACTICE* §§ 4.00-4.07, at 67-89 (1975); Greenhill & Murto, *Governmental Immunity*, 49 TEXAS L. REV. 462 (1971); Holder, *Negligent Selection of Hospital Staff*, 223 J.A.M.A. 833 (1973); McCoid, *The Care Required of Medical Practitioners*, 12 VAND. L. REV. 549, 598-605 (1959); Comment, *Hospital Liability for the Negligence of Physicians: Some Needed Legal Sutures*, 26 U. FLA. L. REV. 844 (1974); Comment, *The Hospital-Physician Relationship: Hospital Responsibility for Malpractice of Physicians*, 50 WASH. L. REV. 385 (1975). See also Dietz, Baird, & Berul, *The Medical Malpractice Legal System*, MALPRACTICE COMMISSION REPORT, APP., at 87, 125, 134 (1973).

49. *E.g.*, *Bender v. Dingwerth*, 425 F.2d 378, 381 (5th Cir. 1970); *Prestegord v. Glenn*, 441 S.W.2d 185 (Tex. 1969); *Rosenthal v. Blum*, 529 S.W.2d 102, 104 (Tex. Civ. App.—Waco 1975, no writ).

50. *Hart v. Van Zandt*, 399 S.W.2d 791, 792 (Tex. 1965); *Bowles v. Bourdon*, 148 Tex. 1, 5, 219 S.W.2d 779, 782 (1949).

51. *King v. Flamm*, 442 S.W.2d 679, 680 (Tex. 1969); *Richardson v. Holmes*, 525 S.W.2d 293, 295-98 (Tex. Civ. App.—Beaumont 1975, writ ref'd n.r.e.).

52. *Bender v. Dingwerth*, 425 F.2d 378, 381 (5th Cir. 1970) (delay in treatment); *Shuffield v. Taylor*, 125 Tex. 601, 603, 83 S.W.2d 955, 957 (1935) (delay in treatment); *Thorning v. Boriski*, 283 S.W. 912, 913 (Tex. Civ. App.—Texarkana 1926, writ dismiss'd).

53. *Richardson v. Holmes*, 525 S.W.2d 293, 297 (Tex. Civ. App.—Beaumont 1975, writ ref'd n.r.e.).

that prior consultation would have prevented his injury.<sup>54</sup>

Discussions of negligence in the area of medical malpractice have centered to a great extent on the types of expert testimony which are admissible to show the standard of care from which the defendant-physician allegedly departed.<sup>55</sup> This question has been of great importance since a defendant could obtain a directed verdict if the plaintiff failed to produce an expert who could testify according to the standard established in the jurisdiction of the suit.<sup>56</sup> The courts developed two well-defined rules governing the quality of the expert testimony required to establish the standard of care.<sup>57</sup> The first of these rules is the "locality" rule which requires, in its strictest interpretation, that the standard of care for a defendant-physician be established by testimony of another physician practicing in the same locality as the defendant, such testimony dealing with the recognized standard of care of physicians in that particular community.<sup>58</sup> This rule grew out of recognition that it would be unfair to hold a country doctor, practicing in an isolated community, to the same standard of care that one would hold a physician practicing in a big city close to hospitals, medical schools, and other centers of informational exchange.<sup>59</sup> Many variations of the strict locality rule have been developed including a "modified" strict locality rule which allows an expert outside of the particular community to testify if it is shown that he is familiar with practices within the particular community.<sup>60</sup> Another is the "same or similar" locality rule, allowing testimony of practices in a community similar to that of the defendant.<sup>61</sup> Finally, the "general

54. *Henson v. Tom*, 473 S.W.2d 258, 263 (Tex. Civ. App.—Texarkana 1971, writ ref'd n.r.e.).

55. *Dunham v. Elder*, 306 A.2d 568, 570 (Md. App. 1973); *Ethicon, Inc. v. Parten*, 520 S.W.2d 527, 534 (Tex. Civ. App.—Houston [14th Dist.] 1975, no writ). See generally McCoid, *The Care Required of Medical Practitioners*, 12 VAND. L. REV. 549, 558-60, 614-21 (1959); Comment, *Medical Malpractice—Expert Testimony*, 60 NW. U.L. REV. 834 (1966).

56. *Dunham v. Elder*, 306 A.2d 568, 570 (Md. App. 1973); see *Rayner v. John Buist Chester Hosp.*, 526 S.W.2d 637, 638-39 (Tex. Civ. App.—Waco 1975, writ ref'd n.r.e.). See also J. PERDUE, *THE LAW OF TEXAS MEDICAL MALPRACTICE* § 6.01, at 108 (1975).

57. The two rules are the "locality" rule and the "same school" rule. For enunciation of the "locality" rule see *Tefft v. Wilcox*, 6 Kan. 33, 42-43 (1870); *Turner v. Stoker*, 289 S.W. 190, 194 (Tex. Civ. App.—Eastland 1926, writ ref'd). For the "same school" rule, see *Force v. Gregory*, 27 A. 1116, 1117 (Conn. 1893); *Floyd v. Michie*, 11 S.W.2d 657, 659 (Tex. Civ. App.—Austin 1928, no writ).

58. *Almli v. Updegraff*, 447 P.2d 586, 587-88 (Ariz. App. 1968); *Govin v. Hunter*, 374 P.2d 421, 424 (Wyo. 1962); see Note, *An Evaluation of Changes in the Medical Standard of Care*, 23 VAND. L. REV. 729, 730 (1970).

59. *Small v. Howard*, 128 Mass. 131, 132 (1880).

60. *Sing v. Owens*, 205 P.2d 3, 6 (Cal. 1949); *Teig v. St. John's Hosp.*, 387 P.2d 527, 531 (Wash. 1963); see Ellin, *The Law of Medical Malpractice in Maryland: A Plaintiff's Dilemma*, 3 U. BALT. L. REV. 207, 208 (1974).

61. E.g., *Gramm v. Boener*, 56 Ind. 497, 500 (1877); *Burk v. Foster*, 69 S.W. 1096, 1097 (Ky. App. 1902); *Turner v. Stoker*, 289 S.W. 190, 193-94 (Tex. Civ. App.—Eastland 1926, writ ref'd).

neighborhood" rule allows testimony of the practice within that "area coextensive with the medical and professional means available in those centers that are readily accessible for appropriate treatment of the patient."<sup>62</sup> Virtually every American jurisdiction has at one time or another accepted some form of the locality rule.<sup>63</sup>

The locality rule has been greatly criticized both because it perpetuates negligence if the standard in the community is a negligent one,<sup>64</sup> and because it often burdens a plaintiff with the difficulty of finding an expert from the same community to testify against a brother physician.<sup>65</sup> Presently, the trend is toward more expanded versions of the rule and, in some instances, a national minimum standard.<sup>66</sup> Certainly in light of the changes

62. *Pederson v. Dumouchel*, 431 P.2d 973, 978 (Wash. 1967).

63. See Note, *Negligence—Medical Malpractice—The Locality Rule*, 18 DE PAUL L. REV. 328, 332 § nn.13 & 14 (1968); Annot., 37 A.L.R.3d 420 (1971).

64. Ellin, *The Law of Medical Malpractice in Maryland: A Plaintiff's Dilemma*, 3 U. BALT. L. REV. 207, 216 (1974); McCoid, *The Care Required of Medical Practitioners*, 12 VAND. L. REV. 549, 575 (1959); Note, *An Evaluation of Changes in the Medical Standard of Care*, 23 VAND. L. REV. 729, 731, 747 (1970).

65. This "conspiracy of silence" has been largely attributed to the development of the locality rule. The Secretary's Commission on Medical Malpractice enumerated several reasons for a physician's reluctance to appear in court as an expert witness. These reasons include lost time and income, and the inability to provide care for patients, plus a desire to avoid injuring fellow physicians. HEW, *MEDICAL MALPRACTICE: REPORT OF THE SECRETARY'S COMMISSION ON MALPRACTICE*, at 36-37 (1973) [hereinafter cited as *MALPRACTICE COMMISSION REPORT*]. This difficulty in obtaining expert witnesses has been commented on by many courts. *E.g.*, *L'Orange v. Medical Protective Co.*, 394 F.2d 57, 62 (6th Cir. 1968); *Salgo v. Leland Stanford Jr. Univ. Bd. of Trustees*, 317 P.2d 170, 175 (Cal. Dist. Ct. App. 1957); *Pederson v. Dumouchel*, 431 P.2d 973, 977 (Wash. 1967). It has also been the subject of articles. See Kelner, *The Silent Doctors—The Conspiracy of Silence*, 5 U. RICH. L. REV. 119 (1970); Note, *Intimidation of Plaintiff's Witness in a Malpractice Suit by Cancellation of Insurance*, 63 NW. U.L. REV. 873 (1969). With the present trend toward liberalization of the locality rule in most jurisdictions, it seems that the conspiracy of silence will gradually cease to be a barrier to a plaintiff's suit since experts from other areas may testify concerning the standard of care. This trend was recognized by the Secretary's Malpractice Commission in making its recommendation that the medical profession establish pools from which experts could be drawn. *MALPRACTICE COMMISSION REPORT*, at 37 (1973).

The recognition of less stringent locality rules, however, will not eliminate another important reason for the existence of a conspiracy of silence. Many physicians feel that discipline of a physician should come from within the profession rather than through the courts. This problem was pointed out in Capron, *Informed Consent in Catastrophic Disease Research and Treatment*, 123 U. PA. L. REV. 340, 436 (1974), discussing Dr. Michael DeBakey's refusal to testify. See *Karp v. Cooley*, 349 F. Supp. 827 (S.D. Tex. 1972), *aff'd*, 493 F.2d 408 (5th Cir.), *cert. denied*, 419 U.S. 845 (1974). For discussions of the conspiracy of silence, see J. PERDUE, *THE LAW OF TEXAS MEDICAL MALPRACTICE* § 2.04, at 31 n.70 (1975); W. PROSSER, *THE LAW OF TORTS* § 32, at 164 & n.60, § 39, at 227 & n.3 (4th ed. 1971); Ellin, *The Law of Medical Malpractice in Maryland: A Plaintiff's Dilemma*, 3 U. BALT. L. REV. 207, 214-15 (1974); McCoid, *The Care Required of Medical Practitioners*, 12 VAND. L. REV. 549, 631-32 (1959).

66. Compare *Geraty v. Kaufman*, 162 A. 33, 36 (Conn. 1932) and *Tvedt v. Haugen*, 294 N.W. 183, 187 (N.D. 1940) with *Brune v. Belinkoff*, 235 N.E.2d 793, 798 (Mass. 1968) and *Webb v. Jorns*, 488 S.W.2d 407, 411 (Tex. 1972). See also Note, *An*

in communication and transportation since the formulation of the rule—standardization of medical schools and development of state licensing requirements—the reason for the rule no longer exists.<sup>67</sup> Texas has recently abandoned adherence to a “same or similar” locality rule in favor of a national minimum standard;<sup>68</sup> with such a standard, the locality becomes only one factor to be considered.<sup>69</sup> The recognition of certain minimum safe procedures which should not vary in any locality would seem to be the best rule and will, if generally accepted, probably have the effect of raising the minimum standard of care.<sup>70</sup>

The second rule developed by the courts is that the defendant-physician

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*Evaluation of Changes in the Medical Standard of Care*, 23 VAND. L. REV. 729, 733-41 (1970). As of 1973, 26 jurisdictions still adhered to the locality rule, 21 accepted an expanded version, and one state, Massachusetts, rejected it completely. Dietz, Baird, & Berul, *The Medical Malpractice Legal System*, MALPRACTICE COMMISSION REPORT, APP., at 134 (1973).

67. See Note, *An Evaluation of Changes in the Medical Standard of Care*, 23 VAND. L. REV. 729, 732-33 & nn. 14, 16, 17 & 18 (1970). See also Ellin, *The Law of Medical Malpractice in Maryland: A Plaintiff's Dilemma*, 3 U. BALT. L. REV. 207, 216-19 (1974); McCoid, *The Care Required of Medical Practitioners*, 12 VAND. L. REV. 549, 573-75 (1959). *Contra*, King & Coe, *The Wisdom of the Strict Locality Rule*, 3 U. BALT. L. REV. 221, 228-33 (1974).

68. *Webb v. Jorns*, 488 S.W.2d 407, 411 (Tex. 1972). Whether or not the court in deciding *Webb* intended to establish a national minimum standard of care rule for all situations is uncertain. The court, in rejecting the defendant's contention that the testimony of the plaintiff's expert witness should be excluded because it did not comply with the community standard, did not expressly state that it was abandoning Texas' long-established “same or similar” locality rule in favor of a national standard, but merely allowed expert testimony that there are “certain minimum safe and accepted practices and procedures that cannot vary in any locality . . . since the human tolerance to certain conditions are uniform and apply to all persons wherever they may be.” *Id.* at 411. The court noted that the community standard demands at a minimum that “one exercise ordinary care commensurate with equipment, skills and time available . . . . Any other treatment of the rule would mean that some communities would be measured by standards which fall beneath those universally regarded as ordinary medical standards.” *Id.* at 411. It is possible, then, that the Texas Supreme Court might adhere to a national standard for very common medical procedures while still applying a “same or similar” locality standard to those more complicated procedures. See Note, *An Evaluation of Changes in the Medical Standard of Care*, 23 VAND. L. REV. 729, 737-38 (1970). The Fifth Circuit, however, in applying Texas law recently held that the plaintiff had the burden of producing medical testimony to determine how a reasonably careful and prudent physician would have acted under the same or similar circumstances with no mention of locality. *Karp v. Cooley*, 493 F.2d 408, 419 n.11 (5th Cir.), *cert. denied*, 419 U.S. 845 (1974). It should be noted that the *Webb* decision was probably not available to the surveyors for the Secretary's Malpractice Commission Report who showed that Texas accepted an expanded locality rule. Dietz, Baird, & Berul, *The Medical Malpractice Legal System*, MALPRACTICE COMMISSION REPORT, APP., at 134 (1973).

69. See, e.g., *Brune v. Belinkoff*, 235 N.E.2d 793, 798 (Mass. 1968); *Fernandez v. Baruch*, 232 A.2d 661, 666 (N.J. Super. Ct. App. Div. 1967), *rev'd on other grounds*, 244 A.2d 109 (N.J. 1968); *Douglas v. Bussabarger*, 438 P.2d 829, 837-38 (Wash. 1968).

70. McCoid, *The Care Required of Medical Practitioners*, 12 VAND. L. REV. 549, 575 (1959); Note, *An Evaluation of Changes in the Medical Standard of Care*, 23 VAND. L. REV. 729, 747 (1970).

should be judged by a standard set by one who adhered to the same school of practice.<sup>71</sup> Furthermore, the school professed by the defendant had to be a generally recognized one with sufficient uniformity of practice to allow a standard to be shown.<sup>72</sup> The reason for the rule was the inability of the jury to understand and weigh the intricacies of each school's methods.<sup>73</sup> Today with accreditation of medical schools under the control of the AMA's Liaison Committee on Medical Education and the Association of American Medical Colleges,<sup>74</sup> medical education has become standardized to such a degree that the former question of a medical "school" has evolved into a question of a medical "specialty."<sup>75</sup> To the extent that the "same school" rule is still viable, it is now a requirement relating to testimony of an expert to establish a standard of care for a specialist.<sup>76</sup> Generally, specialists are held to a higher standard of care than general practitioners since they hold themselves out as having greater knowledge and skill in their specialty area.<sup>77</sup> The standard of care for a specialist must be established by another specialist in the same area or one closely related, although most courts will allow a specialist to establish the standard for a general practitioner if it is shown that he is familiar with the general practice area.<sup>78</sup>

Under both rules it is agreed that customary practice is the standard.<sup>79</sup> This is a deviation from the rule in other negligence actions that conformity with established custom is only evidence of due care.<sup>80</sup> Apparently, the

71. *E.g.*, *Force v. Gregory*, 27 A. 1116, 1117 (Conn. 1893); *Patten v. Wiggen*, 51 Me. 594, 598 (1862); *Nelson v. Dahl*, 219 N.W. 941, 942 (Minn. 1928); *Atkinson v. American School of Osteopathy*, 144 S.W. 816, 821 (Mo. 1912).

72. *Nelson v. Harrington*, 40 N.W. 228, 231 (Wis. 1888) (refusing to recognize "clairvoyant" school). For a discussion of the various schools of practice mentioned in the cases such as allopathy, homeopathy or osteopathy, see McCoid, *The Care Required of Medical Practitioners*, 12 VAND. L. REV. 549, 560 n.62 (1959).

73. *Force v. Gregory*, 27 A. 1116, 1117 (Conn. 1893).

74. *See Medical Education in the United States*, 210 J.A.M.A. 1455, 1460 (1969).

75. For a discussion of the evolution from "same school" to "specialty," see McCoid, *The Care Required Of Medical Practitioners*, 12 VAND. L. REV. 549, 560-69 (1959). *See also* Annot., 85 A.L.R.2d 1022 (1962). For a survey of specialists in the United States, see Note, *Medical Specialties and the Locality Rule*, 14 STAN. L. REV. 884 (1962).

76. *See Karp v. Cooley*, 349 F. Supp. 827 (S.D. Tex. 1972), *aff'd*, 493 F.2d 408 (5th Cir.), *cert. denied*, 419 U.S. 845 (1974); *Wilson v. Scott*, 412 S.W.2d 299 (Tex. 1967).

77. *E.g.*, *Ayers v. Parry*, 192 F.2d 181, 184 (3d Cir. 1951), *cert. denied*, 343 U.S. 980 (1952); *Worster v. Caylor*, 110 N.E.2d 337, 339 (Ind. 1953), *overruled on other grounds*, *New York C. & St. L. R.R. v. Henderson*, 146 N.E.2d 531 (Ind. 1957); *Rule v. Cheeseman*, 317 P.2d 472, 478 (Kan. 1957).

78. Keeton, *Annual Survey of Texas Law: Torts*, 24 SW. L.J. 3, 15 (1970). *Compare King v. Flamm*, 442 S.W.2d 679, 681 (Tex. 1969) *with Wilson v. Scott*, 412 S.W.2d 299, 302 (Tex. 1967).

79. Note, *An Evaluation of Changes in the Medical Standard of Care*, 23 VAND. L. REV. 729, 741-42 (1970). *Contra*, *Helling v. Carey*, 519 P.2d 981, 983 (Wash. 1974). *See also Charfoos*, *Helling: The Law of Medical Malpractice Rewritten*, 2 OHIO NORTH L. REV. 692 (1975).

80. *Texas & Pac. Ry. v. Behymer*, 189 U.S. 468, 470 (1903); *see W. PROSSER, THE LAW OF TORTS* § 33, at 166-68 (4th ed. 1971).

reason is that "custom" is based on the practice of those in the profession of good standing and the belief that such a custom would necessarily be "good medical practice."<sup>81</sup> Logically, however, such a conclusion does not necessarily follow. Despite the fact that the trend toward expanded locality rules will, in most cases, have the effect of raising the customary practice standard, it seems the interests of justice would be better served by allowing conformity with customary practice to be considered as only evidence of due care rather than a conclusive consideration.<sup>82</sup>

A final consideration is the fact that a physician is not liable for mistakes in judgment.<sup>83</sup> Although honest errors of judgment are often difficult to distinguish from negligence, this rule affords some protection for a physician.<sup>84</sup> It is closely related to the "same school" rule in that if a physician can show that a diagnostic procedure or treatment is part of a generally accepted practice and, therefore, it was reasonable for him to rely on the results, he will not be liable for any resulting harm even though the treatment or procedure differs from that of the plaintiff's expert.<sup>85</sup>

#### PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS

In response to inflationary increases in the cost of hospital and other health care services,<sup>86</sup> Congress in 1972 passed an amendment to the Social Security Act creating regional reviewing organizations to assist in regulation of federal medical assistance programs.<sup>87</sup> The purpose of the legislation is

81. See W. PROSSER, *THE LAW OF TORTS* § 32, at 163-65 (4th ed. 1971).

82. See Note, *An Evaluation of Changes in the Medical Standard of Care*, 23 VAND. L. REV. 729, 747 (1970). *Contra*, McCoid, *The Care Required of Medical Practitioners*, 12 VAND. L. REV. 549, 609 (1959).

83. *Loudon v. Scott*, 194 P. 488, 492 (Mont. 1920); *Belk v. Schweizer*, 149 S.E.2d 565, 570 (N.C. 1966); *King v. Flamm*, 442 S.W.2d 679, 681 (Tex. 1969); *Graham v. Gautier*, 21 Tex. 111, 120 (1858).

84. *Graham v. Gautier*, 21 Tex. 111, 120 (1858); *Chasco v. Providence Memorial Hosp.*, 476 S.W.2d 385, 388 (Tex. Civ. App.—El Paso 1972, no writ); *Domina v. Pratt*, 13 A.2d 198, 200 (Vt. 1940).

85. *Graham v. Alcoa S.S. Co.*, 201 F.2d 423, 426 (3d Cir. 1953); *Bruce v. United States*, 167 F.Supp. 579, 589 (S.D. Cal. 1958); *McHugh v. Audet*, 72 F. Supp. 394, 399 (M.D. Pa. 1947); *Schueler v. Strelinger*, 204 A.2d 577, 584 (N.J. 1964); *Costa v. Regents of Univ. of Calif.*, 254 P.2d 85, 93 (Cal. App. 1953).

86. Note, *Professional Standards Review and the Limitation of Health Services: An Interpretation of the Effect of Statutory Immunity on Medical Malpractice Liability*, 54 B.U.L. REV. 931, 931 nn.1 & 3 (1974); Note, *Federally Imposed Self-Regulation of Medical Practices: A Critique of the Professional Standards Review Organization*, 42 GEO. WASH. L. REV. 822, 825 n.12 (1974) (noting that two years after enactment of the Medicare program, the number of days for which hospitalization benefits were payable was 27% higher than originally anticipated).

87. Social Security Amendments of 1972, 42 U.S.C. § 1320c-19 (Supp. II, 1972). Since the enactment of this legislation, many articles have been written speculating on its probable effectiveness. See generally White & Zimmerly, *Professional Standards Review Organizations (PSROs)—What Do They Mean to the Lawyer?* 10 FORUM 393 (1974); Woolley, *PSRO's and HMO's—What Do They Mean to the Lawyer?*, 10 FORUM 417, 418-19 (1974); Note, *Professional Standards Review and the Limitation of Health Serv-*

to increase the effectiveness and decrease the cost of hospital admissions and extended courses of treatment<sup>88</sup> provided to beneficiaries of Medicare, maternal, child health, and other federally funded programs.<sup>89</sup> This is to be effectuated through the development of national norms recommending appropriate limitations on treatments and hospital stays for certain specified conditions.<sup>90</sup> These regional reviewing organizations, known as Professional Standards Reviewing Organizations (PSRO's), will review treatment proposals (for those conditions for which a norm has been established) received from physicians and institutions furnishing services under federal programs both prior to and during treatment.<sup>91</sup> When a physician feels that his patient should have more than the minimum amount of care authorized by the norm due to the idiosyncratic nature of the patient's condition, he should request approval of the proposed treatment from the PSRO prior to initiating treatment or as soon as the need for increased care becomes apparent.<sup>92</sup> If he fails to do so and his treatment above the established norm is later disapproved by the PSRO, the physician faces the possibility of denial of reimbursement<sup>93</sup> or, in repeated instances of overtreatment, exclusion from future participation in the programs.<sup>94</sup> It should be noted that PSRO's review only health care services provided in or by institutions unless the

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*ices: An Interpretation of the Effect of Statutory Immunity on Medical Malpractice Liability*, 54 B.U.L. REV. 931 (1974); Comment, *PSRO: Malpractice Liability and the Impact of the Civil Immunity Clause*, 62 GEO. L.J. 1499 (1974); Note, *Federally Imposed Self-Regulation of Medical Practice: A Critique of the Professional Standards Review Organization*, 42 GEO. WASH. L. REV. 822, 823-24 (1974); Note, *PSRO: A Status Report on Medical Peer Review under the 1972 Social Security Act Amendments*, 6 LOYOLA U.L.J. (CHI.) 90 (1975); Note, *Comparative Approaches to Liability for Medical Maloccurrences*, 84 YALE L.J. 1141, 1161-63 (1975).

88. 42 U.S.C. §§ 1320c-4(a)(1), 4(a)(2), 5(b)(1) & (2), 5(d) (Supp. II, 1972).

89. See *id.* §§ 1320c, 1320c-7 (Supp. II, 1972).

90. See *id.* §§ 1320c-5(d), 4(a)(2)(B), 5(b)(1). The legislation calls for a national council of physicians to develop national norms based on a range of acceptable standards which the PSRO's will then use in developing local standards. Compare *id.* § 1320c-5(c)(1) with *id.* § 1320c-5(a). See also Comment, *PSRO: Malpractice Liability and the Impact of the Civil Immunity Clause*, 62 GEO. L.J. 1499, 1502 (1974). For a critical discussion of PSRO adoption of local custom as the standard which, in conjunction with the immunity clause, could make custom a "mandatory" defense, see Note, *Comparative Approaches to Liability for Medical Maloccurrences*, 84 YALE L.J. 1141, 1161-63 (1975).

91. 42 U.S.C. §§ 1320c-4(a)(2), 5(d) (Supp. II, 1972).

92. See Note, *Professional Standards Review and the Limitation of Health Services: An Interpretation of the Effect of Statutory Immunity on Medical Malpractice Liability*, 54 B.U.L. REV. 931, 936-38 (1974). See also 42 U.S.C. § 1320c-7(a) (Supp. II, 1972). It has been suggested that in such a situation, it might be appropriate for a physician and patient to enter into a formal agreement in which the patient agrees to pay for all services above the PSRO established norm. See Note, *Federally Imposed Self-Regulation of Medical Practice: A Critique of the Professional Standards Review Organization*, 42 GEO. WASH. L. REV. 822, 834-37 (1974).

93. 42 U.S.C. § 1320c-7(a) (Supp. II, 1972).

94. 42 U.S.C. § 1320c-9(b) (Supp. II, 1972).

Secretary approves review of other services.<sup>95</sup> In conjunction with the establishment of these norms and required reliance on them except in special instances, the statute provides immunity from malpractice liability but only if it is shown that health care providers exercised due care in relying on PSRO norms.<sup>96</sup> The effect of this rather confusing qualified immunity provision is to allow possible liability for malpractice in the case of a physician who, in reliance on the norm, failed to provide services that should have been rendered in the exercise of due care.<sup>97</sup> On the other hand, if a physician makes an honest recommendation for treatment above the norm which is rejected by the PSRO, he may protect himself from malpractice liability, but then he is placed in the unfortunate position of either withholding services which he feels are necessary, or proceeding with such services with the prospect of not being reimbursed for them.<sup>98</sup> It has also been suggested that the immunity provisions will force physicians to practice defensive medicine to the extent of recommending treatment above the norm in every questionable case, an evil which the legislation was intended, in part, to combat.<sup>99</sup>

The advantages of immunity for PSRO reviewers are also dependent upon the exercise of due care.<sup>100</sup> How far a reviewer must go in investigating each request for more extensive treatment and to how high a standard of care he is held in disapproving a course of treatment suggested by the attending physician are open questions for which there are no statutory or common law precedents.<sup>101</sup> The situation at least raises the possibility that a reviewer might be inclined to "rubber-stamp" additional treatment proposals purely to

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95. *Id.* § 1320c-4(g). A PSRO must specifically request approval of the Secretary for authority to review outpatient services. *Id.* § 1320c-4(g).

96. *Id.* § 1320c-16(c)(2).

97. Note, *Professional Standards Review and the Limitation of Health Services: An Interpretation of the Effect of Statutory Immunity on Medical Malpractice Liability*, 54 B.U.L. REV. 931, 936 & nn.40 & 42 (1974).

98. *Id.* at 933 & n.25, 937; see Note, *Federally Imposed Self-Regulation of Medical Practice: A Critique of the Professional Standards Review Organization*, 42 GEO. WASH. L. REV. 822, 838-42 (1974). This article also points out that the self-regulatory nature of PSRO adoption of custom as the standard will not effectively force physicians to critically evaluate the necessity of customary practices in which they presently indulge. Note, *Federally Imposed Self-Regulation of Medical Practice: A Critique of the Professional Standards Review Organization*, 42 GEO. WASH. L. REV. 822, 843 & n.92 (1974).

99. Note, *Professional Standards Review and the Limitation of Health Services: An Interpretation of the Effect of Statutory Immunity on Medical Malpractice Liability*, 54 B.U.L. REV. 931, 943 & n.82 (1974). See also Note, *Federally Imposed Self-Regulation of Medical Practice: A Critique of the Professional Standards Review Organization*, 42 GEO. WASH. L. REV. 822, 838 (1974) (discussing purpose of legislation to eliminate practice of defensive medicine).

100. 42 U.S.C. § 1320c-16(b) (Supp. II, 1972).

101. Note, *Professional Standards Review and the Limitation of Health Services: An Interpretation of the Effect of Statutory Immunity of Medical Malpractice Liability*, 54 B.U.L. REV. 931, 941-42 (1974).



avoid subjecting himself to malpractice liability.<sup>102</sup> On the other hand, the legislation is an attempt to face the burgeoning problem of increasing health care costs to the government under medical assistance programs. Its effectiveness will depend on how realistic the established norms are and how seriously each member of the health care field takes his responsibility to comply with the legislative requirements.

A question related to the establishment of PSRO norms and the functioning of PSRO's is the effect that these norms will have on recognized standards of patient care and treatment outside the sphere of federal assistance.<sup>103</sup> It is intended that PSRO norms will parallel the standards of care developed by the common law in those areas where the customary practice is of acceptable quality.<sup>104</sup> Of course, PSRO norms would have the effect of raising the standard in those areas where local practice might be considered deficient.<sup>105</sup> It has been argued that acceptance of national minimum standards of care would have the effect of raising the general level of care in the nation,<sup>106</sup> and certainly PSRO norms would be persuasive standards for those jurisdictions which accept a larger geographical area standard or even a national standard. On the other hand, the fact that PSRO legislation is basically aimed at cutting costs would seem to work at cross purposes with the idea that increasingly higher standards of care are desirable to provide patients with the best possible care commensurate with advances in medical research and treatment. The result could easily be different standards of care for private patients and those receiving federal assistance.<sup>107</sup>

#### THE DOCTRINE OF RES IPSA LOQUITUR

In the past 20 years, the doctrine of res ipsa loquitur has been an issue in the trial of medical malpractice cases in a substantially greater percentage than in previous years.<sup>108</sup> It is a significant evidentiary rule for a jury to

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102. *Id.* at 943-44.

103. See B. DECKER & P. BONNER, *PSRO: ORGANIZATION FOR REGIONAL PEER REVIEW* 19 (1973). The authors note that PSRO norms will have the effect of serving as educational tools for members of the medical profession in those types of cases for which norms are developed.

104. 42 U.S.C. § 1320c-5(a) (Supp. II, 1972).

105. Comment, *PSRO: Malpractice Liability and the Impact of the Civil Immunity Clause*, 62 GEO. L.J. 1499, 1503-05 (1974).

106. Note, *An Evaluation of Changes in the Medical Standard of Care*, 23 VAND. L. REV. 729, 747 (1970).

107. See Note, *Professional Standards Review and the Limitation of Health Services: An Interpretation of the Effect of Statutory Immunity on Medical Malpractice Liability*, 54 B.U.L. REV. 931, 943 & n.83 (1974).

108. MALPRACTICE COMMISSION REPORT, at 29 (1973); see Dietz, Baird, & Berul, *The Medical Malpractice Legal System*, MALPRACTICE COMMISSION REPORT, APP., at 129 (1973). In the frequency of application of the doctrine of res ipsa loquitur to malpractice appeals, the percentage increased from 6.3% in pre-1950 cases to 14.0% for

consider in a case which lacks direct evidence and is useful in countering the "conspiracy of silence."<sup>109</sup> California courts have been the forerunners in the application of the doctrine, having decided 60 percent of the appeals involving *res ipsa* in the 10 year period from 1961 to 1971.<sup>110</sup>

The doctrine was originally applied in situations such as those involving injury to parts of the body not under treatment, or those in which a foreign object was left in a patient after an operation.<sup>111</sup> The California courts indicated an increasing willingness to expand the application of the doctrine to include any situation in which it could be said that it is common knowledge that the incident was more likely than not the result of negligence.<sup>112</sup> Today California allows a conditional *res ipsa* jury instruction, whereby the jury is allowed to use *res ipsa* if they first find certain circumstantial facts to be true.<sup>113</sup> The situation seems replete with opportunities for abuse by plaintiffs who merely allege their injuries and the fact that it is common knowledge such injuries do not occur without negligence.<sup>114</sup>

Texas is one of several jurisdictions which has generally refused to allow the application of *res ipsa* to medical malpractice cases.<sup>115</sup> This policy is

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the period from 1950 to 1960. For the period from 1961 to 1971 the percentage of cases appealed in which *res ipsa* was applied was 13.4%. *Id.* at 129. Moreover, plaintiffs have achieved a substantially higher degree of success on appeal where *res ipsa* is a major issue. *Id.* at 137; see 1 D. LOUISELL & H. WILLIAMS, *MEDICAL MALPRACTICE* ¶¶ 14.01-.09, at 418-60 (1973); J. PERDUE, *THE LAW OF TEXAS MEDICAL MALPRACTICE* §§ 5.00-5.04, at 89-106 (1975); 2 S. SPEISER, *THE NEGLIGENCE CASE: RES IPSA LOQUITUR* §§ 24.1-.34, at 196-292 (1972).

109. *Res ipsa* allows a plaintiff to take his case to the jury on the basis of circumstantial evidence which shows that: (1) the occurrence is one that does not normally happen in the absence of someone's negligence; (2) the instrumentality causing the harm was within the exclusive control of the defendant; and (3) there was no voluntary action by the plaintiff which contributed to his injury. Some courts require a fourth element—that the evidence of the true explanation be more readily accessible to the defendant than to the plaintiff. W. PROSSER, *THE LAW OF TORTS* § 39, at 214 (4th ed. 1971). The doctrine of *res ipsa loquitur* is particularly well-suited to the situation surrounding the trial of a medical malpractice case since it eliminates the need for expert testimony in many cases. Frequently, the plaintiff has no knowledge of the incident which caused his injury because he was anesthetized for surgery. 1 D. LOUISELL & H. WILLIAMS, *MEDICAL MALPRACTICE* ¶ 14.02, at 421 (1960); J. PERDUE, *THE LAW OF TEXAS MEDICAL MALPRACTICE* § 5.00, at 90 (1975).

110. Dietz, Baird & Berul, *The Medical Malpractice Legal System*, MALPRACTICE COMMISSION REPORT, APP., at 154-55 (1973).

111. *Ybarra v. Spangard*, 154 P.2d 687, 689-90 (Cal. 1944) (injury to patient's shoulder during appendectomy operation); *Ales v. Ryan*, 64 P.2d 409, 415 (Cal. 1936) (sponge left in patient's body).

112. See *Timbrell v. Suburban Hosp., Inc.*, 47 P.2d 737, 739 (Cal. 1935). For a discussion of the development of the *res ipsa* doctrine in California, see Kayajanian, *Confronting the Conspiracy of Silence: We Have a Tiger by the Tail*, 6 U.W.L.A. L. REV. 40 (1974).

113. *Clark v. Gibbons*, 58 Cal. Rptr. 125, 132 (Cal. 1967); *Quintal v. Laurel Grove Hosp.*, 41 Cal. Rptr. 577, 583 (Cal. 1964).

114. See MALPRACTICE COMMISSION REPORT, at 28-29.

115. There are no Texas Supreme Court cases applying the doctrine of *res ipsa* in

probably a result dictated by language in early malpractice cases to the effect that the law presumes a doctor discharges his full duty of care to his patient, and that such presumption is defeated only by affirmative proof of breach of duty and resulting injury.<sup>116</sup> Moreover, the use of the doctrine places an undue burden on the defendant doctor to come forward with what in many instances might amount to affirmative proof of non-negligence.<sup>117</sup>

It has been suggested that the refusal to apply the doctrine in Texas is due not so much to a general belief that it is inapplicable to malpractice cases as to the factual situations in which the question has arisen.<sup>118</sup> This belief is supported by the language in some recent cases to the effect that, contrary to the general rule, *res ipsa* might be applied to cases in which the injuries are obviously the result of someone's negligence or where the lack of care and skill are obvious enough to be determined by laymen.<sup>119</sup> These cases suggest that the doctrine might be applied if the factual situation were appropriate.

In discussing the application of *res ipsa*, it is necessary to distinguish between those cases in which a layman could say that a particular injury would not occur in the absence of negligence on someone's part,<sup>120</sup> and those cases in which expert testimony would be required to show that the

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medical malpractice situations. Texas Courts of Civil Appeals, however, have generally held the doctrine to be inapplicable. *Bell v. Umstattd*, 401 S.W.2d 306, 313 (Tex. Civ. App.—Austin 1966, writ *dism'd*); *Barker v. Heaney*, 82 S.W.2d 417, 419 (Tex. Civ. App.—San Antonio 1935, writ *dism'd*). *Contra*, *Martin v. Eschelman*, 33 S.W.2d 827, 830 (Tex. Civ. App.—Texarkana 1930, writ *ref'd*); Dietz, Baird, & Berul, *The Medical Malpractice Legal System*, MALPRACTICE COMMISSION REPORT, APP., at 134, 146 (1973). Apparently the writers of this article based their conclusion that Texas allows application of the doctrine on the 1930 civil appeals case of *Martin v. Eschelman*. Their research further indicated, however, that *res ipsa* has not been the deciding issue in any appellate decision from 1950 to 1971, the time period covered by their research. Dietz, Baird, & Berul, *The Medical Malpractice Legal System*, MALPRACTICE COMMISSION REPORT, APP., at 142 (1973). This fact coupled with cases stating that *res ipsa* is not applicable to medical malpractice cases indicates that the doctrine has been generally rejected by the Texas courts. See J. PERDUE, *THE LAW OF TEXAS MEDICAL MALPRACTICE* § 5.01, at 91-94 (1975). For a list of other states which have applied or rejected the doctrine, see Dietz, Baird, & Berul, *The Medical Malpractice Legal System*, MALPRACTICE COMMISSION REPORT, APP., at 134 (1973).

116. *Kaster v. Woodson*, 123 S.W.2d 981, 982 (Tex. Civ. App.—Austin 1938, writ *dism'd*); *Floyd v. Michie*, 11 S.W.2d 657, 658 (Tex. Civ. App.—Austin 1928, no writ. *dism'd*); *Floyd v. Michie*, 11 S.W.2d 657, 658 (Tex. Civ. App.—Austin 1928 no writ).

117. MALPRACTICE COMMISSION REPORT, at 28 (1973).

118. J. PERDUE, *THE LAW OF TEXAS MEDICAL MALPRACTICE* § 5.01, at 92 (1975).

119. *Hunter v. Robison*, 488 S.W.2d 555, 560 (Tex. Civ. App.—Dallas 1972, writ *ref'd n.r.e.*); *Thomas v. Beckering*, 391 S.W.2d 771, 775 (Tex. Civ. App.—Tyler 1965, writ *ref'd n.r.e.*); *Henderson v. Mason*, 386 S.W.2d 879, 882 (Tex. Civ. App.—El Paso 1964, no writ). *But see* *Louis v. Parchman*, 493 S.W.2d 310, 321 (Tex. Civ. App.—Fort Worth 1973, writ *ref'd n.r.e.*); *Goodnight v. Phillips*, 418 S.W.2d 862, 868 (Tex. Civ. App.—Texarkana 1967, writ *ref'd n.r.e.*).

120. *Ybarra v. Spangard*, 154 P.2d 687, 690 (Cal. 1944).

occurrence would not have happened unless someone had been negligent.<sup>121</sup> In both situations proof of proximate cause is required, but here, too, it is possible that there are circumstances in which a layman could infer a causal connection.<sup>122</sup> Certainly in the latter situation, a plaintiff would make a more convincing case if he simply established by expert testimony a classic malpractice case consisting of establishing the applicable standard of care, the defendant's departure therefrom, and the plaintiff's resulting injury, rather than requesting an expert to support a case based on *res ipsa*. In the former case, however, where the negligence and causal connection are so obvious as to be within the comprehension of laymen, it seems that many deserving plaintiffs would be well-served by the adoption of the *res ipsa* doctrine in malpractice cases.<sup>123</sup> In order to avoid placing an undue burden on the defendant, *res ipsa* could be applied in such a manner as to allow the jury to infer negligence. Even if the defendant offered no rebutting evidence, the jury could still find for either party.<sup>124</sup> The application of *res ipsa* could result in saving trial time and expense to both parties by elimination of the necessity for certain kinds of proof including expert testimony. Furthermore, should any pre-litigation screening panels or boards be established, it seems that cases to which *res ipsa* might apply would be especially appropriate for hearing by such a panel since the elements of a *res ipsa* case are well defined, and the fact issues to be determined are generally few in number.

#### INFORMED CONSENT

Although a recognized part of American jurisprudence for the past 60 years,<sup>125</sup> the doctrine of informed consent has only recently emerged as a major area of litigation in medical malpractice cases.<sup>126</sup> Today there are

121. *Goodnight v. Phillips*, 418 S.W.2d 862, 868 (Tex. Civ. App.—Texarkana 1967,

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writ ref'd n.r.e.).

122. Compare *Hunter v. Robison*, 488 S.W.2d 555, 557-58 (Tex. Civ. App.—Dallas 1972, writ ref'd n.r.e.) with *Ybarra v. Spangard*, 154 P.2d 687, 690-91 (Cal. 1944). See generally J. PERDUE, *THE LAW OF TEXAS MEDICAL MALPRACTICE* § 5.04, at 106 (1975); Morris, *Res Ipsa Loquitur in Texas*, 26 TEXAS L. REV. 257, 259 (1948).

123. See MALPRACTICE COMMISSION REPORT, at 29 (1973).

124. For a discussion of various theories relating to the procedural effect of *res ipsa*, see W. PROSSER, *THE LAW OF TORTS* § 40, at 228-35 (4th ed. 1971).

125. See *Theodore v. Ellis*, 75 So. 655, 660 (La. 1917); *Hunter v. Burroughs*, 96 S.E. 360, 366-68 (Va. 1918). See generally 2 D. LOUISELL & H. WILLIAMS, *MEDICAL MALPRACTICE* ¶ 22.01-.09, at 594.43-.64 (1973); J. PERDUE, *THE LAW OF TEXAS MEDICAL MALPRACTICE* §§ 9.00-9.05, at 194-218 (1975); Capron, *Informed Consent in Catastrophic Disease Research and Treatment*, 123 U. PA. L. REV. 340 (1974); Waltz & Scheuneman, *Informed Consent to Therapy*, 64 NW. U.L. REV. 628 (1970); Comment, *Informed Consent in Medical Malpractice*, 55 CALIF. L. REV. 1396 (1967).

126. Dietz, Baird, & Berul, *The Medical Malpractice Legal System*, MALPRACTICE COMMISSION REPORT, APP., at 129-37, 147 (1973). See generally Annot., 79 A.L.R.2d 1028 (1961).

two main issues involved in cases deciding informed consent questions: the first is the theory of recovery to be employed, either battery or negligence, and the second is the standard by which to judge the extent of the disclosure required of the physician.<sup>127</sup> The battery theory of recovery is obviously a much stricter standard since a plaintiff would only need to prove the failure to disclose a risk involved which would thereby invalidate any consent to treatment given.<sup>128</sup> Under the battery theory, there is no necessity that the plaintiff prove a bad result from the treatment.<sup>129</sup> Under the negligence theory, the plaintiff may not recover unless he proves both that he would not have consented to treatment had he been informed of the undisclosed risk and that he was injured by the occurrence of the risk of which he was not informed.<sup>130</sup>

For many years, courts discussed the failure to fulfill the duty to disclose risks inherent in medical and surgical procedures in terms of assault and battery or negligent diagnosis and treatment by the physician.<sup>131</sup> Probably as a result of the phenomenal advances made in the treatment of disease, particularly in the area of catastrophic diseases such as cancer, there has been a proliferation of lawsuits for injury resulting from the treatment of disease.<sup>132</sup> With these suits has come a recognition by the majority of courts that the harm involved is the result not of negligent treatment, diagnosis or a completely unauthorized procedure, but of negligent failure to inform the patient of the risks involved in treatment.<sup>133</sup> That "[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body" is the underlying premise of the doctrine of informed consent.<sup>134</sup> It is clear that in order to give truly "informed" consent, the patient must be aware of and be able to evaluate the available options including the hazards of the treatment itself, the alterna-

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127. Capron, *Informed Consent in Catastrophic Disease Research and Treatment*, 123 U. PA. L. REV. 340, 348 (1974).

128. *E.g.*, *Abril v. Syntex Laboratories, Inc.*, 364 N.Y.S.2d 281, 282 (Sup. Ct. 1975); *Barnette v. Potenza*, 359 N.Y.S.2d 432, 436 (Sup. Ct. 1974); *Gray v. Grunnagle*, 223 A.2d 663, 668-69 (Pa. 1966).

129. McCoid, *A Reappraisal of Liability for Unauthorized Medical Treatment*, 41 MINN. L. REV. 381, 384 (1956).

130. *E.g.*, *Karp v. Cooley*, 493 F.2d 408, 421-22 (5th Cir.), *cert. denied*, 419 U.S. 845 (1974).

131. *Wilson v. Scott*, 412 S.W.2d 299, 302 (Tex. 1967); *Wilkinson v. Vesey*, 295 A.2d 676, 685-88 (R.I. 1972).

132. Compare Capron, *Informed Consent in Catastrophic Disease Research and Treatment*, 123 U. PA. L. REV. 340, 350-53 (1974) with Dietz, Baird, & Berul, *The Medical Malpractice Legal System*, MALPRACTICE COMMISSION REPORT, APP., at 129-37 (1973).

133. *Wilson v. Scott*, 412 S.W.2d 299, 302 (Tex. 1967); *accord*, *Canterbury v. Spence*, 464 F.2d 772, 781-83 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972).

134. *Schloendorff v. Society of N.Y. Hosp.*, 105 N.E. 92, 93 (N.Y. 1914), *overruled on other grounds*, *Bing v. Thunig*, 163 N.Y.S.2d 1 (Ct. App. 1957).

tives to the treatment, and the probable results if the condition remains untreated.<sup>135</sup>

The doctrine of informed consent is multi-faceted, with many undefined areas, which are the source of confusion and disagreement among courts and commentators.<sup>136</sup> The majority of courts which have dealt with the question, however, have recognized that a physician has an affirmative duty to reveal the risks involved in therapy to his patient in the same way that he has a duty to skillfully diagnose and treat the patient.<sup>137</sup> While most courts agree that the duty exists at the beginning of the proposed course of treatment,<sup>138</sup> it is logical to assume that the duty would also arise at any time during the treatment process in which a new procedure involving risks is contemplated.<sup>139</sup> Giving information and receiving informed consent is a continuing area of interchange between the physician and his patient.<sup>140</sup>

The majority of jurisdictions hold that the duty to disclose arises when other physicians practicing in the community would make the particular disclosure.<sup>141</sup> This situation must be established by the plaintiff as part of his burden of proof by the use of expert testimony.<sup>142</sup> Recently, however, some courts have suggested that allowing the medical community to set the standard overlooks the fact that there can be no recovery by a patient if there is no existing medical custom to disclose, despite the fact that in the particular situation in question it might have been unreasonable to withhold information.<sup>143</sup> Consequently, these courts have ruled that the determina-

135. *Canterbury v. Spence*, 464 F.2d 772, 780, 787-88 (D.C. Cir. 1972); *Dunham v. Wright*, 423 F.2d 940, 943-46 (3d Cir. 1970); *Bowers v. Talmage*, 159 So. 2d 888 (Fla. Dist. Ct. App. 1963); *Mason v. Ellsworth*, 474 P.2d 909, 918-19 (Wash. App. 1970).

136. See Capron, *Informed Consent in Catastrophic Disease Research and Treatment*, 123 U. PA. L. REV. 340, 347 n.20, 406 n.155 (1974); Waltz & Scheuneman, *Informed Consent to Therapy*, 64 Nw. U.L. REV. 628 n.1 (1970). See also *Cobbs v. Grant*, 104 Cal. Rptr. 505, 511-12 (1972).

137. See Dietz, Baird, & Berul, *The Medical Malpractice Legal System*, MALPRACTICE COMMISSION REPORT, APP., at 126 (1973).

138. *Cobbs v. Grant*, 104 Cal. Rptr. 505, 514 (1972); accord, *Natanson v. Kline*, 350 P.2d 1093, 1107 (Kan. 1960); *Wilkinson v. Vesey*, 295 A.2d 676, 687-88 (R.I. 1972).

139. Capron, *Informed Consent in Catastrophic Disease Research and Treatment*, 123 U. PA. L. REV. 340, 368-69 (1974). See also *Karp v. Cooley*, 493 F.2d 408, 421 (5th Cir.), cert. denied, 419 U.S. 845 (1974).

140. Capron, *Informed Consent in Catastrophic Disease Research and Treatment*, 123 U. PA. L. REV. 340, 369 (1974).

141. *Canterbury v. Spence*, 464 F.2d 772, 783 (D.C. Cir. 1972); accord, *Aiken v. Clary*, 396 S.W.2d 668, 674-76 (Mo. 1965); *Wilson v. Scott*, 412 S.W.2d 299, 302 (Tex. 1967).

142. *Wilkinson v. Vesey*, 295 A.2d 676, 686 & n.8 (R.I. 1972); *Wilson v. Scott*, 412 S.W.2d 299, 302 (Tex. 1967). Where the case involves complete silence on the part of the physician, however, it is agreed that no expert testimony is required. *Collins v. Meeker*, 424 P.2d 488, 494-95 (Kan. 1967); *Wilkinson v. Vesey*, 295 A.2d 676, 686 (R.I. 1972).

143. *Canterbury v. Spence*, 464 F.2d 772, 783 (D.C. Cir. 1972); *Cobbs v. Grant*, 104 Cal. Rptr. 505, 513-14 (1972); *Wilkinson v. Vesey*, 295 A.2d 676, 688 (R.I. 1972).

tion of when the duty to disclose arises is a non-medical decision which should be based on what is reasonable under the circumstances.<sup>144</sup> Of course, in most cases, it will be necessary to establish by expert testimony the fact that there were undisclosed risks involved, but the ultimate determination of reasonableness will not be based on conformity or non-conformity with an existing medical community standard.<sup>145</sup> Although the question of precisely when the duty to disclose arises has not been discussed in Texas, apparently it would be decided in favor of the medical community standard.<sup>146</sup>

Once it has been established that a duty to disclose exists, the next question to be resolved is how much should be disclosed and the standard by which the extent of the disclosure should be measured. Although some courts have required "full" disclosure,<sup>147</sup> most would probably agree that there is no necessity to discuss risks of a particular procedure commonly known to all or those of such a low probability and minimal effect as to be negligible.<sup>148</sup> It should be noted, however, that the duty to disclose increases with the seriousness of the possible harm despite the fact that the probability of occurrence is very low.<sup>149</sup> Again, the majority of courts, including Texas, which have dealt with the scope of the duty to disclose have stated that the standard is that of the "reasonable medical practitioner of the same school and same or similar community under the same or similar circumstances. . . ."<sup>150</sup> Further, the standard is a general one and is not limited by the experience of the particular defendant-physician.<sup>151</sup> Here, too, there is a recently established minority view that the extent of the disclosure should be based on the patient's need for information material to making his decision of whether to undergo a specified treatment.<sup>152</sup> This view is founded on the theory that to allow the medical community to set the

144. *Canterbury v. Spence*, 464 F.2d 772, 785 (D.C. Cir. 1972); *Cobbs v. Grant*, 104 Cal. Rptr. 505, 514 (1972); *Wilkinson v. Vesey*, 295 A.2d 676, 688 (R.I. 1972).

145. *See Canterbury v. Spence*, 464 F.2d 772, 785 (D.C. Cir. 1972); *Wilkinson v. Vesey*, 295 A.2d 676, 688 (R.I. 1972).

146. *See Wilson v. Scott*, 412 S.W.2d 299, 302 (Tex. 1967).

147. *Salgo v. Leland Stanford J. Univ. Bd. of Trustees*, 317 P.2d 170, 181 (Cal. Dist. Ct. App. 1957); *Woods v. Brumlop*, 377 P.2d 520, 524-25 (N.M. 1962); *Getchell v. Mansfield*, 489 P.2d 953, 956 (Ore. 1971) (must disclose all material risks).

148. *Cobbs v. Grant*, 104 Cal. Rptr. 505, 514-15 (1972); *Wilkinson v. Vesey*, 205 A.2d 676, 689 (R.I. 1972).

149. *Cobbs v. Grant*, 104 Cal. Rptr. 505, 515 (1972); *Gravis v. Physicians & Surgeons Hosp.*, 415 S.W.2d 674, 679 (Tex. Civ. App.—San Antonio 1967), *rev'd on other grounds*, 427 S.W.2d 310 (Tex. 1968).

150. *Wilson v. Scott*, 412 S.W.2d 299, 302 (Tex. 1967); *accord*, *Shetter v. Rochelle*, 409 P.2d 74, 86 (Ariz. Ct. App. 1965), *modified*, 411 P.2d 45 (Ariz. Ct. App. 1966); *Govin v. Hunter*, 374 P.2d 421, 424 (Wyo. 1962).

151. *Anderson v. Hooker*, 420 S.W.2d 235, 238-39 (Tex. Civ. App.—El Paso 1967, writ ref'd n.r.e.).

152. *Canterbury v. Spence*, 464 F.2d 772, 786-87 (D.C. Cir. 1972); *Cobbs v. Grant*, 104 Cal. Rptr. 505, 515 (1972); *Wilkinson v. Vesey*, 295 A.2d 676, 689 (R.I. 1972).

standard of disclosure would, in effect, allow a doctor to make the decision for the patient by revealing or not revealing certain risks.<sup>153</sup> Based on the realization that the standard of materiality to a particular patient is difficult to establish other than by the patient himself, and that such a subjective standard would be highly prejudicial to the defendant-doctor, these minority decisions have held that the required materiality is shown when a reasonable person, in what the doctor knows or should know is the patient's position, would attach significance to the risks or risks undisclosed.<sup>154</sup> Expert testimony would be necessary to show the undisclosed risks in most cases.<sup>155</sup>

Finally, in order to recover on proof of negligent failure to disclose, a patient must show that had he known of the potential harm prior to accepting treatment, his decision would have been different; he must prove a causal connection.<sup>156</sup> The best evidence of causal connection is *that of the patient himself*; however, his testimony is of questionable credibility since his outlook is colored by the fact of the undisclosed risk.<sup>157</sup> Apparently, courts have dealt with this problem by simply allowing the factfinder to decide whether or not he believes the patient's testimony.<sup>158</sup> Cases which have discussed the problem in greater depth, however, have held that the patient's testimony is only one factor, and that the true test should be whether or not a prudent person in the patient's position would have made the same decision when confronted with all the facts.<sup>159</sup> The question has never been directly discussed in Texas.<sup>160</sup>

There are three recognized exceptions to the duty to disclose. Generally, there is no duty when the situation is an emergency requiring immediate

153. *Canterbury v. Spence*, 464 F.2d 772, 784 (D.C. Cir. 1972); Capron, *Informed Consent in Catastrophic Disease Research and Treatment*, 123 U. PA. L. REV. 340, 367-68, 369 n.69 (1974).

154. *Wilkinson v. Vesey*, 295 A.2d 676, 689 (R.I. 1972); *accord*, *Canterbury v. Spence*, 464 F.2d 772, 787 (D.C. Cir. 1972); *Cobbs v. Grant*, 104 Cal. Rptr. 505, 515 (1972).

155. *Wilkinson v. Vesey*, 295 A.2d 676, 688 (R.I. 1972).

156. *Karp v. Cooley*, 493 F.2d 408, 421-22 (5th Cir.), *cert. denied*, 419 U.S. 845 (1974). In order to establish causal connection, it is necessary to show (1) that an unrevealed risk which should have been made known did, in fact, materialize, (2) that it resulted in harm to the patient, and (3) that disclosure would have resulted in a decision against the treatment. *Id.* at 422; *see Canterbury v. Spence*, 464 F.2d 772, 790 (D.C. Cir. 1972).

157. *Canterbury v. Spence*, 464 F.2d 772, 790 (D.C. Cir. 1972).

158. *Id.* at 790.

159. *Cobbs v. Grant*, 104 Cal. Rptr. 505, 515-16 (1972).

160. The opinion in *Karp v. Cooley* discussed the necessity of establishing a causal connection between harm and undisclosed risks and the Texas cases dealing with the problem. The discussion, however, centers on the causal relationship between a particular medical procedure and resulting harm rather than on the causal connection which must be shown in informed consent cases, that the disclosure would have resulted in a decision against the proposed treatment. *Karp v. Cooley*, 493 F.2d 408, 421-22 (5th Cir.), *cert. denied*, 419 U.S. 845 (1974).



action for the preservation of life or limb.<sup>161</sup> Another exception defers the duty to disclose to the physician's exercise of "therapeutic privilege." This is his prerogative when disclosure of possible risks would be detrimental to the patient's progress under the proposed treatment.<sup>162</sup> In both instances, it is recommended that, if possible, the doctor discuss the inherent risks with relatives of the patient.<sup>163</sup> The third exception arises when the patient is made aware of the possibility of harm but prefers not to be informed of the nature of the risks.<sup>164</sup>

Another aspect of the doctrine of informed consent is brought into focus when there are several doctors treating a patient and consulting with the primary physician.<sup>165</sup> The questions raised in this situation deal with how much information must be conveyed to the patient regarding each phase of treatment and who has the primary responsibility to inform.<sup>166</sup> The better view is that each doctor active in diagnosis and treatment should be responsible for disclosure of risks at least within his specialty field, despite referral by another doctor.<sup>167</sup> Texas apparently follows the view that the consent obtained by the primary physician is sufficient for the consulting doctors.<sup>168</sup>

In the future, the doctrine of informed consent will probably assume greater importance as patients realize that their cause of action is actually for a failure to disclose risks rather than negligent treatment.<sup>169</sup> It seems that the "reasonable and prudent person" standards rather than those of the medical community provide the best balance of physician and patient interests. These standards have the advantage of allowing laymen to determine what is reasonable to disclose on the basis of expert testimony as to what risks are involved, rather than allowing this determination to be made by physicians whose judgment might be colored by what they see as a need for treatment, or who might be reluctant to testify against a fellow

161. *Gravis v. Physicians & Surgeons Hosp.*, 415 S.W.2d 674, 679 (Tex. Civ. App.—San Antonio 1967), *rev'd on other grounds*, 427 S.W.2d 310 (Tex. 1968).

162. *Wilson v. Scott*, 412 S.W.2d 299, 301 (Tex. 1967). For a discussion of the therapeutic privilege, see Capron, *Informed Consent in Catastrophic Disease Research and Treatment*, 123 U. PA. L. REV. 340, 387-92 (1974).

163. MALPRACTICE COMMISSION REPORT, at 75 (1973).

164. *Cobbs v. Grant*, 104 Cal. Rptr. 505, 516 (1972).

165. *Karp v. Cooley*, 493 F.2d 408, 422 n.19 (5th Cir.), *cert. denied*, 419 U.S. 845 (1974); *Wilkinson v. Vesey*, 295 A.2d 676, 688-89 (R.I. 1972).

166. See Capron, *Informed Consent in Catastrophic Disease Research and Treatment*, 123 U. PA. L. REV. 340, 368 n.66 (1974). See also MALPRACTICE COMMISSION REPORT, at 74-75 (1973).

167. *Wilkinson v. Vesey*, 295 A.2d 676, 689 (R.I. 1972).

168. *Weiser v. Hampton*, 445 S.W.2d 224, 230-31 (Tex. Civ. App.—Houston [1st Dist.] 1969, writ ref'd n.r.e.); *Bell v. Umstatt*, 401 S.W.2d 306, 313 (Tex. Civ. App.—Austin 1966, writ dism'd).

169. One author states that informed consent might emerge as a hybrid of assault and battery and negligence. Capron, *Informed Consent in Catastrophic Disease Research and Treatment*, 123 U. PA. L. REV. 340, 403-23 (1974).

professional.<sup>170</sup> Furthermore, these standards relieve the physician of the undue burden of an affirmative showing of non-negligent non-disclosure which is placed on him due to the standards of disclosure based on the subjective testimony of the injured patient.<sup>171</sup> It is suggested that the guidelines detailing the basic elements of informed consent promulgated by the Department of Health, Education and Welfare for experimentation involving human subjects might be a standard by which to judge the minimum disclosure required in most cases.<sup>172</sup> Although some cases might call for disclosure of more information than the guidelines require,<sup>173</sup> establishment of a minimum standard of disclosure might have the effect of increasing patient-physician communication, which is the most obvious solution to such an emotionally entangling problem.<sup>174</sup> Patients, too, should assume an affirmative responsibility to request information concerning treatment since they are the ones who have the most to lose from uninformed consent.

#### EXPERT TESTIMONY

It is a generally recognized principle that expert testimony is required to establish liability in the trial of most medical malpractice cases.<sup>175</sup> This testimony is necessary to show the applicable standard of care from which it is alleged that the defendant departed, that such departure was the proximate cause of the plaintiff's injuries,<sup>176</sup> and, in cases relating to the quality

170. *Id.* at 366-69, 406 n.159. Capron also suggests that the standard for determining the proper extent of disclosure and the requisite causation should be a strictly subjective one, despite hardship on a defendant-physician, since any other standard "undermines the fundamental purpose of the informed consent rule, the promotion of individual autonomy." *Id.* at 420.

171. *Canterbury v. Spence*, 464 F.2d 772, 787, 791-92 (D.C. Cir. 1972).

172. DHEW Reg. for the Protection of Human Subjects, 45 C.F.R. §§ 46.103(c) (1975). See also MALPRACTICE COMMISSION REPORT, at 74-75 (1973); Note, *Restructuring Informed Consent: Legal Therapy for the Doctor-Patient Relationship*, 79 YALE L.J. 1533, 1561 (1970).

173. See *Cobbs v. Grant*, 104 Cal. Rptr. 505, 515 (1972) (involved experimental treatments).

174. See *Wilkinson v. Vesey*, 295 A.2d 676, 690 (R.I. 1972); MALPRACTICE COMMISSION REPORT, at 74 (1973).

175. In what is probably the earliest articulated statement of this principle, Judge Taft, writing for the Circuit Court of Ohio, stated:

[W]hen a case concerns the highly specialized art of treating . . . [disease], with respect to which a layman can have no knowledge at all, the court and jury must be dependent on expert evidence. There can be no other guide, and, where want of skill or attention is not thus shown by expert evidence applied to the facts, there is no evidence of it proper to be submitted to the jury.

*Ewing v. Goode*, 78 F. 442, 444 (C.C.S.D. Ohio 1897). For a general discussion of the subject of expert medical testimony see J. PERDUE, *THE LAW OF TEXAS MEDICAL MALPRACTICE* §§ 6.00-6.07, at 108-43 (1975); Steakley, *Expert Medical Testimony in Texas*, 1 ST. MARY'S L.J. 161 (1969); Annot., 81 A.L.R.2d 597 (1962).

176. *Bowles v. Bourdon*, 148 Tex. 1, 4-5, 219 S.W.2d 779, 782 (1949) (expert testimony used to establish standard of care and proximate cause); see *Jordan*, *Expert*

of any consent to treatment given by the patient, that the defendant failed to convey sufficient information under the circumstances to enable the patient to give intelligent and reasoned consent.<sup>177</sup> This rule has developed because courts have recognized that it is patently unfair to judge the actions of a doctor in any given situation on the basis of the average juror's knowledge of diagnosis and treatment of disease.<sup>178</sup>

The medical expert must first be qualified as such according to the usual procedure for qualifying expert witnesses in general.<sup>179</sup> This is a decision which lies within the discretion of the trial judge and will only be overturned for abuse of discretion.<sup>180</sup> The first Texas Supreme Court statement on the subject required that the doctor be of the "same school" as the defendant.<sup>181</sup> This rule was at various times described as requiring testimony of an expert of the "same school of practice"<sup>182</sup> who practices "under the same or similar circumstances."<sup>183</sup> Now it probably is not necessary to show the same school or similar circumstances if it can be shown that the expert has sufficient knowledge of the area in question to be of assistance to the jury in making their determination.<sup>184</sup> The expert may be a specialist who is familiar with the practices of general practitioners; he may simply testify to the existence of certain minimum standards of care which doctors of all schools should follow; or he may be the defendant doctor himself testifying to standards in his own field.<sup>185</sup> Although becoming increasingly more reluctant to do so, many courts have instructed verdicts for defendants because of the plaintiff's failure to present sufficient expert testimony to support his allegations.<sup>186</sup>

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*Testimony—Cause of Present Physical Condition*, 29 TEX. B.J. 805 (1966); Musslewhite, *Medical Causation Testimony in Texas: Possibility Versus Probability*, 23 SW. L.J. 622 (1969); Note, *Informed Consent—A New Basis of Medical Liability in Texas*, 21 SW. L.J. 843 (1967); Annot., 13 A.L.R.2d 11 (1950).

177. *Wilson v. Scott*, 412 S.W.2d 299, 301 (Tex. 1967). See generally Capron, *Informed Consent in Catastrophic Disease Research and Treatment*, 123 U. PA. L. REV. 340 (1974); Annot., 52 A.L.R.2d 1084 (1973).

178. See A. HOLDER, *MEDICAL MALPRACTICE LAW* 60 (1975); Gottlieb, *The Evolution of the Locality Rule*, LEGAL MED. ANN.: 1969 31, 41.

179. See C. McCORMICK, *LAW OF EVIDENCE* § 13, at 29-31 (2d ed. E. Cleary, 1972). See generally Ladd, *Expert Testimony*, 5 VAND. L. REV. 414 (1952).

180. See *Wilson v. Scott*, 412 S.W.2d 299, 303-304 (Tex. 1967); C. McCORMICK, *LAW OF EVIDENCE* § 13, at 30 (2d ed. E. Cleary 1972).

181. *Bowles v. Bourdon*, 148 Tex. 1, 5, 219 S.W.2d 779, 782 (1949).

182. *Porter v. Puryear*, 153 Tex. 82, 87, 262 S.W.2d 933, 935 (1953), *rev'd on other grounds on rehearing*, 153 Tex. 92, 264 S.W.2d 689 (1954).

183. *Wilson v. Scott*, 412 S.W.2d 299, 302 (Tex. 1967).

184. See *Loper v. Andrews*, 404 S.W.2d 300, 305 (Tex. 1966); C. McCORMICK, *LAW OF EVIDENCE* § 13, at 30 (2d ed. E. Cleary 1972).

185. *Webb v. Jorns*, 488 S.W.2d 407, 411 (Tex. 1972) (standard of care which all doctors should follow); *Wilson v. Scott*, 412 S.W.2d 299, 303 (Tex. 1967) (defendant doctor testifying to his own standards); see *King v. Flamm*, 442 S.W.2d 679, 681 (Tex. 1969) (specialist); Keeton, *Annual Survey of Texas Law: Torts*, 24 SW. L.J. 3, 15 (1970).

186. *Compare Snow v. Bond*, 438 S.W.2d 549 (Tex. 1969) with *Lenger v. Physician's*

In qualifying an expert to testify, it is necessary for the court to know the basis of his testimony, such as medical records, personal examination, or hypothetical questions.<sup>187</sup> The medical records must be admissible under evidentiary theories such as prior inconsistent statements or admissions of the defendant,<sup>188</sup> or under the Texas statute providing for admissibility of business records.<sup>189</sup> Testimony based on examination of the plaintiff may be given either by a third-party witness or the defendant-doctor himself.<sup>190</sup> There is conflict in the cases as to whether or not the expert's testimony may be in the form of an opinion concerning the negligent nature of the treatment actually rendered, or in the form of a statement of general procedures followed by the medical community as a whole in performing the type of treatment in question.<sup>191</sup> This is a matter clearly within the discretion of the trial judge.

In considering expert testimony in medical malpractice cases, it is always necessary to distinguish between complete lack of evidence, evidence relating to the negligence of the defendant, and evidence which shows a causal connection between the alleged negligence of the defendant and the injuries sustained by the plaintiff.<sup>192</sup> It is only in rare instances that the causal connection between the negligence and the injury will be inferred without the assistance of expert testimony, due to the complexity of treatments and injuries.<sup>193</sup> Concerning the area of causation, the Texas Supreme Court in *Bowles v. Bourdon*<sup>194</sup> enunciated the general rule that testimony of an

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General Hosp., Inc., 455 S.W.2d 703 (Tex. 1970) and *Bowles v. Bourdon*, 148 Tex. 1, 219 S.W.2d 779 (1949). See also Keeton, *Annual Survey of Texas Laws: Torts*, 24 Sw. L.J. 3, 14-15 (1970).

187. See C. McCORMICK, *LAW OF EVIDENCE* §§ 14-15, at 31-36 (2d ed. E. Cleary 1972); J. PERDUE, *THE LAW OF TEXAS MEDICAL MALPRACTICE* § 6.02 B, at 113-17 (1975); Rheingold, *The Basis of Medical Testimony*, 15 VAND. L. REV. 473 (1962).

188. See C. McCORMICK, *LAW OF EVIDENCE* § 36, at 70-72 & § 262, at 628-31 (2d ed. E. Cleary 1972).

189. TEX. REV. CIV. STAT. ANN. art. 3737e (Supp. 1975); see *Loper v. Andrews*, 404 S.W.2d 300, 304-305 (Tex. 1966); *Hart v. Van Zandt*, 399 S.W.2d 791, 796 (Tex. 1965).

190. *Wilson v. Scott*, 412 S.W.2d 299, 303 (Tex. 1967) (defendant doctor); *Texas State Highway Dep't v. Fillmon*, 150 Tex. 460, 465-66, 242 S.W.2d 172, 175 (1951) (third party witness); *Kinion v. Hyde*, 471 S.W.2d 920, 922 (Tex. Civ. App.—Amarillo 1971, writ ref'd n.r.e.) (third party witness).

191. *Webb v. Jorns*, 488 S.W.2d 407, 411 (Tex. 1972) (allowing testimony of general procedures); *Prestegord v. Glenn*, 441 S.W.2d 185, 187 (Tex. 1969) (testimony regarding specific procedures used admitted); *Snow v. Bond*, 438 S.W.2d 549, 550-51 (Tex. 1969) (testimony regarding specific procedures used, inappropriate).

192. See J. PERDUE, *THE LAW OF TEXAS MEDICAL MALPRACTICE* § 6.05, at 129-36 (1975); Musslewhite, *Medical Causation Testimony in Texas: Possibility Versus Probability*, 23 Sw. L.J. 622, 641-43 (1969).

193. Generally, cases in which no expert testimony is required are those in which the negligence is of a type obvious to laymen. E.g., *Harle v. Krchnak*, 422 S.W.2d 810, 815 (Tex. Civ. App.—Houston [1st Dist.] 1967, writ ref'd n.r.e.) (sponge left in patient's body); *Thompson v. Barnard*, 142 S.W.2d 238, 240 (Tex. Civ. App.—Waco 1940), *aff'd*, 138 Tex. 277, 158 S.W.2d 486 (1942) (sponge left in patient's body).

194. 148 Tex. 1, 219 S.W.2d 779 (1949).

expert establishing only that the doctor's alleged negligence *could* have been a cause of the patient's injuries is not sufficient to take the issue to the jury, since the jury could only speculate as to the cause of injury.<sup>195</sup> Some courts have interpreted this rule to require that the testimony be in terms of strict medical probability, a standard so rigid as to render it virtually impossible to find an expert willing to make such a statement except in the most clear-cut cases.<sup>196</sup> The rule has been relaxed somewhat by different courts in allowing testimony (1) that the defendant's act set into motion a chain of events in which the foreseeable result was the plaintiff's injury,<sup>197</sup> (2) that the defendant's act was a "possible" cause of injury when the surrounding facts and circumstances support the proposition that the act was in fact a cause of the injury,<sup>198</sup> or (3) that the defendant's act was a "possible" cause when the expert's testimony as a whole amounts to reasonable probability.<sup>199</sup> It seems settled that a plaintiff does not have to disprove every other possible cause of injury arising from the defendant's negligence to prove causation.<sup>200</sup> Apparently, however, some confusion remains as to whether or not testimony couched in terms of a "possibility" rather than "probability" is admissible,<sup>201</sup> whether or not the surrounding facts and circumstances should be considered in conjunction with the expert's testimony,<sup>202</sup> and whether or not it is the substance rather than the form of the expert's testimony which should be considered.<sup>203</sup> In fairness, it seems that "possibility" testimony, when surrounded by facts strongly indicating causation, should be sufficient to obtain submission of a proximate cause issue to the jury.

195. *Id.* at 9-10, 210 S.W.2d at 785.

196. *Simms v. Gafney*, 227 S.W.2d 848, 850 (Tex. Civ. App.—Texarkana 1950, writ ref'd n.r.e.). It seems clear that one of the problems involved in obtaining expert medical testimony of causation is the difference in the medical and legal definition of "probable." See Markus, *Semantics of Traumatic Causation*, 12 CLEV.-MAR. L. REV. 233, 240-46 (1963); Musslewhite, *Medical Causation Testimony in Texas: Possibility Versus Probability*, 23 Sw. L.J. 622, 640 & n.92 (1969).

197. *Porter v. Puryear*, 153 Tex. 82, 90, 262 S.W.2d 933, 938 (1953).

198. *Hart v. Van Zandt*, 399 S.W.2d 791, 799 (Tex. 1965) (Smith, J., dissenting).

199. *Parker v. Employers Mut. Liab. Ins. Co.*, 440 S.W.2d 43, 46-47 (Tex. 1969) (workman's compensation case).

200. *Rose v. Friddell*, 423 S.W.2d 658, 664 (Tex. Civ. App.—Tyler 1967, writ ref'd n.r.e.). It is definitely settled that a plaintiff has proven his case when he shows that his injury resulted from either one of two possible causes, both of which resulted from the defendant's negligence. *Webb v. Jorns*, 488 S.W.2d 407, 411 (Tex. 1972).

201. *Gibson v. Avery*, 463 S.W.2d 277, 280 (Tex. Civ. App.—Fort Worth 1970, writ ref'd n.r.e.) ("medical expert can testify as to his opinion as to the cause which produced or probably produced, or might have produced or which could possibly have produced . . ."). See also *Bender v. Dingwerth*, 425 F.2d 378, 381 (5th Cir. 1970).

202. *Richardson v. Holmes*, 525 S.W.2d 293, 298 (Tex. Civ. App.—Beaumont 1975, writ ref'd n.r.e.) (instruction that jury could consider circumstantial evidence in ascertaining facts held improper).

203. *Lenger v. Physician's Gen. Hosp., Inc.*, 455 S.W.2d 703, 707 (Tex. 1970) ("reasonable medical probability" is not the standard by which an expert medical witness must testify).

## DEFENSIVE MEDICINE

A natural outgrowth of the recent increase in medical malpractice litigation is the practice of defensive medicine.<sup>204</sup> Defensive medicine has been defined as "the alteration of modes of medical practice, induced by the threat of liability, for the principal purposes of forestalling the possibility of lawsuits by patients as well as providing a good legal defense in the event such lawsuits are instituted."<sup>205</sup> The practice of defensive medicine has been categorized as positive defensive medicine, wherein a physician conducts a test or procedure which may not be medically justified but which is aimed at preventing or defending against medical-legal liability, and as negative defensive medicine, when he refuses, out of fear of a malpractice suit, to undertake a treatment or procedure involving risk which might be beneficial to the patient.<sup>206</sup> The Secretary's Commission on Medical Malpractice recognized a third form of defensive medicine as physicians' reluctance to publish in medical journals case reports of adverse effects of diagnostic and therapeutic procedures, for fear that such publication might be used as evidence in a lawsuit.<sup>207</sup>

While formal and informal surveys have indicated that 50 to 70 percent of doctors admit that they practice some forms of defensive medicine at various times and in varying degrees, it is difficult to obtain empirical data since what may be defensive medicine to one practitioner might be simply good medical practice to another.<sup>208</sup> At any rate, it is undeniable that increases in positive defensive medicine through increased use of medical facilities and equipment and extended treatment periods have led, in part, to a substantial increase in the cost of medical care.<sup>209</sup> It is also undoubted, however, that

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204. For discussions of the general problem of defensive medicine, see MALPRACTICE COMMISSION REPORT, at 14 (1973); A. HOLDER, *MEDICAL MALPRACTICE LAW* 414-15 (1975); Bernzweig, *Defensive Medicine*, MALPRACTICE COMMISSION REPORT, APP., at 38 (1973); Hershey, *The Defensive Practice of Medicine, Myth or Reality*, 50 MILBANK MEMORIAL Q. 69 (1972); Project, *The Malpractice Threat: A Study of Defensive Medicine*, 1971 DUKE L.J. 939.

205. MALPRACTICE COMMISSION REPORT, at 14 (1973).

206. Project, *The Malpractice Threat: A Study of Defensive Medicine*, 1971 DUKE L.J. 939, 942-43, 949-50 (1971).

207. MALPRACTICE COMMISSION REPORT, at 14 (1973).

208. Bernzweig, *Defensive Medicine*, MALPRACTICE COMMISSION REPORT, APP., at 39 (1973); see Project, *The Malpractice Threat: A Study of Defensive Medicine*, 1971 DUKE L.J. 939, 953-54 (1971).

209. Bernzweig, *Defensive Medicine*, MALPRACTICE COMMISSION REPORT, APP., at 39-40 (1973). Examples of positive defensive medicine are excessive use of routine x-ray diagnostic procedures, laboratory tests, additional follow-up office visits, and more instances of hospitalization in borderline cases. *Id.* at 39.

The Duke study attributed part of the problem of increased health care costs to the lack of cost constraints placed on a physician. Due to the technical nature of the services offered, there is very little opportunity for consumers to indicate preferences for one service over another and thereby exercise the en masse cost constraint displayed in other markets. Consequently, much of the decision-making process in medical treatment

such increased care has in many cases resulted in better health care for the patient.<sup>210</sup> To the extent that physicians are reluctant to publish reports of unsuccessful procedures and engage in the practice of negative defensive medicine, medical progress and experimentation are hindered.<sup>211</sup>

While most investigators of the malpractice crisis will admit that the use of defensive medical practices is widespread, and some will hail these practices as highly beneficial to present and future patients, the lack of statistical information on the subject and the difficulty of obtaining such information results in abstract discussions of this phenomenon.<sup>212</sup> The Secretary's Commission on Medical Malpractice found that defensive medicine is a by-product of the malpractice problem and not a causative factor in itself.<sup>213</sup> The commission stated that reduction of the use of defensive medicine would follow a reduction of the problems inherent in medical-legal liability.<sup>214</sup> The commission could make no more specific recommendations on dealing with the problem than to state that overutilization of health-care resources should be attacked by physician-directed regulatory efforts, and medical organizations should exert "moral suasion over physicians who avoid professional responsibility out of fear of malpractice liability."<sup>215</sup> As the issues of medical malpractice liability are brought into focus, the effects of defensive medicine should also sharpen.

#### STATUTE OF LIMITATIONS

Limitation of the time in which an action may be brought is a development of statutory law.<sup>216</sup> There are two bases for establishment of a time limit on the filing of suits: first, that a plaintiff will not delay in pressing a meritorious claim, and second, that the ability to ascertain the true facts of a

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rests with the individual physician who is free to allocate medical resources to both beneficial and non-beneficial uses. It seems, though, that threat of litigation might be a deciding factor in the allocation of such resources thus resulting in the practice of defensive medicine. Project, *The Malpractice Threat: A Study of Defensive Medicine*, 1971 DUKE L.J. 939, 943-47 (1971).

210. Bernzweig, *Defensive Medicine*, MALPRACTICE COMMISSION REPORT, APP., at 39 (1973).

211. MALPRACTICE COMMISSION REPORT, at 14 (1973).

212. Both courts and commentators have mentioned briefly the existence of the problem. *E.g.*, Guilmet v. Campbell, 188 N.W.2d 601, 610 (Mich. 1971) (Black J., dissenting); Gorney, *A Doctor's Plea for Intelligent Compromise*, 7 TRIAL, May/June, 1971, at 53; Keeton, *Compensation for Medical Accidents*, 121 U. PA. L. REV. 590, 598-600 (1973); Tierney, *Contractual Aspects of Malpractice*, 19 WAYNE L. REV. 1457, 1472-73 (1973); Note, *Contractual Liability in Medical Malpractice—Sullivan v. O'Connor*, 24 DE PAUL L. REV. 212, 226 (1974).

213. MALPRACTICE COMMISSION REPORT, at 15 (1973).

214. *Id.* at 15.

215. *Id.* at 15.

216. Comment, *Texas Adopts the Discovery Rule for Limitations in Medical Malpractice Actions*, 1 ST. MARY'S L.J. 77 (1969).

case decreases steadily as time passes.<sup>217</sup> Statutes of limitations are now so well established in all jurisdictions that they are seldom the subject of legislative discussion, and any change must come through judicial interpretation.<sup>218</sup>

As courts and lawyers have reached general agreement that an action for medical malpractice is basically an action for negligence, there has also been general agreement that such an action is governed by the provisions of the statutes of limitations relating to torts.<sup>219</sup> In Texas, the statute of limitations provides that any action for "injury done to the person of another" shall be initiated and prosecuted "within two years after the cause of action shall have accrued."<sup>220</sup> Through judicial determination of when a cause of action "accrues,"<sup>221</sup> courts have introduced some flexibility into various statutes of limitations by deciding that the action accrues at the time when an injury is actually sustained or when a medical treatment ends.<sup>222</sup> The rule in Texas, however, was established quite early and states that when the act is

217. *Id.*; see *Chase Sec. Corp. v. Donaldson*, 325 U.S. 304, 314 (1945).

218. See Note, *Developments in the Law—Statutes of Limitations*, 63 HARV. L. REV. 1177, 1185 (1950).

219. 1 D. LOUISELL & H. WILLIAMS, *MEDICAL MALPRACTICE* ¶ 13.03, at 367 (1973). Numerous commentators have discussed the application of various statutes of limitations to medical malpractice actions. See, e.g., J. PERDUE, *THE LAW OF TEXAS MEDICAL MALPRACTICE* §§ 7.00-7.02, at 144-61 (1975); Lillich, *The Malpractice Statute of Limitations in New York and Other Jurisdictions*, 47 CORNELL L.Q. 339 (1962); Note, *Malpractice and the Statute of Limitations*, 32 IND. L.J. 528 (1957); Comment, *Texas Adopts the Discovery Rule for Limitations in Medical Malpractice Actions*, 1 ST. MARY'S L.J. 77 (1969); Note, *Medical Malpractice: A Survey of Statutes of Limitation*, 3 SUFFOLK U.L. REV. 597 (1969); Note, *Torts—Medical Malpractice—Statute of Limitations is Tolloed When the Plaintiff Produces Prima Facie Evidence to Raise Fraudulent Concealment as a Material Issue of Fact*, 5 TEX. TECH. L. REV. 209 (1973).

220. TEX. REV. CIV. STAT. ANN. art. 5526, § 6 (1958). This same statute also provides for a two-year limitations period on actions for oral contracts and wrongful death actions. *Id.* §§ 4, 7. The statute of limitations for written contracts is four years. TEX. REV. CIV. STAT. ANN. art. 5527, § 1 (1958). Furthermore, there are some express provisions contained in the statutes which toll the operation of the statute of limitations in certain circumstances. When the plaintiff is a minor or under some other disability, the statute is tolled until the disability ceases. TEX. REV. CIV. STAT. ANN. art. 5535 (Supp. 1975). When the plaintiff dies, the statute is tolled for one year or until an executor or administrator of the estate is appointed. TEX. REV. CIV. STAT. ANN. art. 5538 (1958). The statute is also tolled for the period of time that a defendant is outside the state. TEX. REV. CIV. STAT. ANN. art. 5537 (1958).

221. In Texas, it is stated that a cause of action does not accrue until "facts exist which authorize the person asserting the claim to seek relief in a court of competent jurisdiction. . . . It involves both the existence of the right and facts sufficient to constitute a cause of action [citations omitted]." *Williams v. Pure Oil Co.*, 124 Tex. 341, 345, 78 S.W.2d 929, 931 (1935).

222. *United States v. Reid*, 251 F.2d 691, 694 (5th Cir. 1958) (action accrues at time of actual injury); *Miami v. Brooks*, 70 So. 2d 306, 308 (Fla. 1954) (action accrues at time of actual injury); *Waldman v. Rohrbaugh*, 215 A.2d 825, 828 (Md. 1966) (action accrues when treatment ends); *Hotelling v. Walther*, 130 P.2d 944, 946 (Ore. 1942) (action accrues when treatment ends).



wrongful as to the plaintiff, the right of action accrues at the time of the act itself regardless of whether or not the plaintiff is immediately aware of any injury.<sup>223</sup>

In an attempt to avoid the harsh results that such a strict interpretation of the limitations statute would have in many instances, courts have developed various theories to either avoid the statute, come under another section of the statute having a longer time limit, or postpone the time at which the statute begins to run. A majority of jurisdictions including Texas have agreed that when a defendant-physician has fraudulently concealed from his patient the existence of an injury which might give rise to a suit, he is estopped to raise the statute of limitations as a defense if suit is brought.<sup>224</sup> The two basic elements of fraudulent concealment are knowledge by the defendant of his negligence and concealment of the negligence from the plaintiff.<sup>225</sup> Some states, in recognition of the fiduciary nature of the physician-patient relationship, have held that mere silence will constitute fraudulent concealment while others have required that there be affirmative acts to conceal.<sup>226</sup>

A second manner in which plaintiffs have been able to avoid the restrictive effect of the statutes of limitations applicable to negligence is by bringing an action based on breach of express or implied contract.<sup>227</sup> Although the general measure of damages recoverable for breach of contract is less than that recoverable for a personal injury suit since, as a rule, no recovery for pain and suffering is allowed,<sup>228</sup> plaintiffs will often attempt to bring an action for breach of contract when a tort action would be barred by limitations.<sup>229</sup> In most jurisdictions, the limitations period for breach of

223. *Houston Water-Works Co. v. Kennedy*, 70 Tex. 233, 236, 8 S.W. 36, 37 (1888). Apparently, Texas does not recognize a distinction between the time the act occurred and the time that injury is sustained.

224. *Texas & Pac. Ry. v. Gay*, 86 Tex. 571, 608, 26 S.W. 599, 614-15 (1894). A finding of fraudulent concealment prevents the running of the statute until the plaintiff learns or should have learned of the injury. *Nichols v. Smith*, 507 S.W.2d 518, 519 (Tex. 1974); *Thompson v. Barnard*, 142 S.W.2d 238, 241 (Tex. Civ. App.—Waco 1940), *aff'd*, 138 Tex. 277, 158 S.W.2d 486 (1942). See generally 1 D. LOISELL & H. WILLIAMS, *MEDICAL MALPRACTICE* ¶ 13.11, at 379.

225. *Carrell v. Denton*, 138 Tex. 145, 148, 157 S.W.2d 878, 879 (1942), *overruled on other grounds*, *Gaddis v. Smith*, 417 S.W.2d 577 (Tex. 1967).

226. *E.g.*, *Hudson v. Moore*, 194 So. 147, 149 (Ala. 1940) (silence); *Draws v. Levin*, 52 N.W.2d 180, 183 (Mich. 1952) (affirmative acts); *Thompson v. Barnard*, 142 S.W.2d 238, 241 (Tex. Civ. App.—Waco 1940), *aff'd*, 138 Tex. 277, 158 S.W.2d 486 (1942) (silence); *Hundley v. Martinez*, 158 S.E.2d 159, 165 (W. Va. 1967) (affirmative acts).

227. *Creighton v. Karlin*, 225 So. 2d 288, 291-92 (La. Ct. App. 1969); see Note, *Medical Malpractice: A Survey of Statutes of Limitation*, 3 SUFFOLK U.L. REV. 597, 600-604 (1969); Comment, *The Implied Contract Theory of Malpractice Recovery*, 6 WILLAMETTE L.J. 275, 280-83 (1970).

228. *Robins v. Finestone*, 127 N.E.2d 330, 332 (N.Y. 1955). *Contra*, *Stewart v. Rudner*, 84 N.W.2d 816, 823-24 (Mich. 1957).

229. *Sellers v. Noah*, 95 So. 167 (Ala. 1923). Many courts seem to hold that a malpractice action is basically a tort action, however, and refuse to allow a suit in contract to be brought. *Huysman v. Kirsch*, 57 P.2d 908, 910 (Cal. 1936); *Foster v.*

contract is longer than that for tort so that a plaintiff in this situation would still have a chance to recover some of his expenses.<sup>230</sup> In Texas, however, a plaintiff would have to prove breach of an express contract in writing to obtain the benefit of the longer limitations period since the limitations period for breach of an oral contract is the same as that for a tort.<sup>231</sup>

A third theory developed by the courts to aid an injured plaintiff whose right to sue has been cut off by limitations is the continuing treatment theory.<sup>232</sup> This is based on a legal fiction stating that the defendant-physician is continuously negligent over the course of the treatment in question, and, therefore, the cause of action does not accrue and the statute does not begin to run until the end of the treatment period.<sup>233</sup> Attempts to plead this theory in order to stretch the limitations period have not been very successful in Texas.<sup>234</sup>

By far the most popular theory of alleviating the consequences of strict application of the statute of limitations has been the discovery rule.<sup>235</sup> Under this theory, the basic limitations period for torts begins to run only at the time that the plaintiff knows or should know of the negligent treatment

Kopp, 100 P.2d 660, 661 (Kan. 1940). See generally Comment, *Texas Adopts the Discovery Rule for Limitations on Medical Malpractice Actions*, 1 ST. MARY'S L.J. 77, 77-78 (1969).

230. Note, *Medical Malpractice: A Survey of Statutes of Limitations*, 3 SUFFOLK U.L. REV. 597, 603, 619 (1969); Comment, *The Implied Contract Theory of Malpractice Recovery*, 6 WILLAMETTE L.J. 275, 280 & n.35 (1970).

231. Compare TEX. REV. CIV. STAT. ANN. art. 5527 (1958) with TEX. REV. CIV. STAT. ANN. art. 5526, §§ 4, 6 (1958). It should be noted that the Medical Professional Liability Study Commission has already recommended that there be no recovery for breach of a contract to cure unless the contract to cure is in writing and signed and notarized. Keeton, *Introduction, Medical Malpractice in Texas*, 7 ST. MARY'S L.J. 733, 734 (1976). Presumably, then, any future malpractice action based on breach of contract would be covered by the four-year statute of limitations if the situation was not within the express provisions of TEX. INS. CODE ANN. art. 5.82, § 4 (Supp. 1975).

232. See Sacks, *Statutes of Limitations and Undiscovered Malpractice*, 16 CLEV.-MAR. L. REV. 65, 67-68 (1967).

233. *Sly v. Van Lengen*, 198 N.Y.S. 608, 610 (N.Y. Misc. 1923); see J. PERDUE, *THE LAW OF TEXAS MEDICAL MALPRACTICE* § 7.02 B, at 151-53 (1975); Comment, *Texas Adopts the Discovery Rule for Limitations in Medical Malpractice Actions*, 1 ST. MARY'S L.J. 77, 79-80 (1969).

234. *Coffman v. Hedrick*, 437 S.W.2d 60, 62 (Tex. Civ. App.—Houston [1st Dist.] 1968, writ ref'd n.r.e.); *McFarland v. Connally*, 252 S.W.2d 486, 488 (Tex. Civ. App.—Fort Worth 1952, no writ).

235. By 1973, 36 jurisdictions had accepted some exception to strict application of the statute of limitations either through use of the discovery rule or the theory of fraudulent concealment. Dietz, Baird, & Berul, *The Medical Malpractice Legal System*, MALPRACTICE COMMISSION REPORT, APP., at 134 (1973). Some jurisdictions hold the discovery rule applicable to all malpractice situations; some hold that it applies only where objects are left in the patient's body. See J. PERDUE, *THE LAW OF TEXAS MEDICAL MALPRACTICE* § 7.02 D, at 157 & n.91 (1975); Note, *Torts-Statute of Limitations in Medical Malpractice Cases—Justice Sought and Almost Attained*, 21 DE PAUL L. REV. 234, 246-47 (1971).

by the physician.<sup>236</sup> The justification for the rule is found in the belief that it is patently unfair to cut off a plaintiff's cause of action before he has had an opportunity to discover his injury.<sup>237</sup> The rule is particularly appropriate for medical malpractice actions since it is often several years before a plaintiff learns of the negligent act of the defendant which has caused his injury.<sup>238</sup> The discovery rule has been applied to many situations including negligent misdiagnosis, negligent radiation treatment, and negligent determination of the proper dosage of medicine, but the most frequent application is found in cases involving a physician's failure to remove a foreign object from the body of the patient.<sup>239</sup> In 1967, after many years of strict application of the two-year statute of limitations,<sup>240</sup> Texas adopted the discovery rule for cases in which foreign objects were left in a patient's body.<sup>241</sup> For five years, the supreme court refused to extend the application of the rule to any other situation,<sup>242</sup> but in 1972 the court held the rule applicable to unsuccessful vasectomies.<sup>243</sup> Presently these are the only two situations in which Texas applies the discovery rule although several jurisdictions have extended it to all cases of medical malpractice.<sup>244</sup>

236. *Huysman v. Kirsch*, 57 P.2d 908, 912-13 (Cal. 1936); *Ayers v. Morgan*, 154 A.2d 788, 794 (Pa. 1959). In cases applying the discovery rule, it is held that the cause of action does not accrue until the plaintiff knows or should know of the injury thereby postponing the happening of the event—accrual of a cause of action—which starts the statute running. See J. PERDUE, *THE LAW OF TEXAS MEDICAL MALPRACTICE* § 7.02 D, at 157 (1975).

237. *Gaddis v. Smith*, 417 S.W.2d 577, 580-81 (Tex. 1967); Comment, *Texas Adopts the Discovery Rule for Limitations in Medical Malpractice Actions*, 1 ST. MARY'S L.J. 77, 84-85 (1969).

238. See Note, *Medical Malpractice: A Survey of Statutes of Limitations*, 3 SUFFOLK U.L. REV. 597, 608 & nn.74 & 76 (1969).

239. E.g., *Davis v. Bonebrake*, 313 P.2d 982, 985-86 (Colo. 1957) (object left in plaintiff's body); *Renner v. Edwards*, 475 P.2d 530, 536 (Idaho 1970) (negligent diagnosis); *Billings v. Sisters of Mercy of Idaho*, 389 P.2d 224, 232 (Idaho 1964) (object left in plaintiff's body); *Hahn v. Claybrook*, 100 A. 83 (Md. Ct. App. 1917) (negligent allocation of medicine); *Lopez v. Swyer*, 279 A.2d 116, 121 (N.J. Super. Ct. 1971), *aff'd*, 300 A.2d 563 (N.J. 1972) (negligent radiation treatment); *Seitz v. Jones*, 370 P.2d 300 (Okla. 1961) (object left in plaintiff's body); *Gaddis v. Smith*, 417 S.W.2d 577, 580 (Tex. 1967) (object left in plaintiff's body); *Morgan v. Grace Hospital, Inc.*, 144 S.E.2d 156, 158 (W. Va. 1965) (object left in plaintiff's body).

240. The rule in Texas until 1967 was announced in *Carrell v. Denton*, 138 Tex. 145, 147-48, 157 S.W.2d 878-79 (1942). Despite the recognition of hardship on a plaintiff, the rule was strictly followed until expressly overruled in *Gaddis v. Smith*, 417 S.W.2d 577, 580 (Tex. 1967). *Stewart v. Janes*, 393 S.W.2d 428 (Tex. Civ. App.—Amarillo 1965, writ ref'd), *cert. denied*, 383 U.S. 962 (1966), *overruled*, *Gaddis v. Smith*, 417 S.W.2d 577 (Tex. 1967) (applying the rule strictly).

241. *Gaddis v. Smith*, 417 S.W.2d 577, 580 (Tex. 1967).

242. *Axcell v. Phillips*, 473 S.W.2d 554, 559 (Tex. Civ. App.—Houston [1st Dist.] 1971, writ ref'd n.r.e.) (negligent severing of nerves during an appendectomy); *Coffman v. Hedrick*, 437 S.W.2d 60, 62 (Tex. Civ. App.—Houston [1st Dist.] 1966, writ ref'd n.r.e.) (negligent diagnosis and treatment).

243. *Hays v. Hall*, 488 S.W.2d 412, 414 (Tex. 1972).

244. Note, *Limitation of Actions—Medical Malpractice—Discovery Rule*, 3 ST. MARY'S L.J. 111, 112 n.5 (1971).

Clearly the acceptance of the discovery rule by the various jurisdictions has been a boon for plaintiffs who do not discover an injury until after the limitations period has already run.<sup>245</sup> Equally as clear, though, is the fact that adoption of the rule has placed a great burden on physicians by extending their period of potential liability indefinitely.<sup>246</sup> Jurisdictions which have rejected the application of the discovery rule have pointed out that it effectively defeats the purpose of the statutes of limitations.<sup>247</sup> At least five states which have enacted special statutes of limitations for medical malpractice actions have included some form of the discovery rule, and also some maximum limitation on the time allowed for discovery.<sup>248</sup> Placing a maximum time limit for discovery of the injury would appear to be the most equitable way of balancing the competing interests of plaintiff and defendant, and it is suggested that Texas should consider not only extension of the discovery rule to other appropriate cases but also adoption of a limitation on the time for discovery greater than that now provided by the two-year statute for torts.

To a certain extent the question of the applicability of the discovery rule in Texas has been rendered moot by the action of the 64th Legislature in adopting a mandatory two-year limitations period for the filing of all medical malpractice claims whether for breach of express or implied contract or tort.<sup>249</sup> Since the statute is expressly applicable only to persons or hospitals

245. See Comment, *Texas Adopts the Discovery Rule for Limitations in Medical Malpractice Actions*, 1 ST. MARY'S L.J. 77, 84-85 (1969); Note, *Medical Malpractice: A Survey of Statutes of Limitation*, 3 SUFFOLK U.L. REV. 597, 614-15 (1969).

246. See Note, *Torts—Statute of Limitations in Medical Malpractice Cases—Justice Sought and Almost Attained*, 21 DE PAUL L. REV. 234, 242-45 (1973).

247. E.g., *Peterson v. Roloff*, 203 N.W.2d 699, 702 (Wis. 1973); Comment, *The Implied Contract Theory of Malpractice Recovery*, 6 WILLAMETTE L.J. 275, 282-83 (1970); Note, *Torts—Medical Malpractice—Statute of Limitations Is Told When the Plaintiff Produces Prima Facie Evidence to Raise Fraudulent Concealment as a Material Issue of Fact*, 5 TEX. TECH. L. REV. 209, 214 (1973).

248. ALA. CODE tit. 7, § 25(1) (1960) (six years from date of act causing injury); CAL. CIV. PROC. CODE § 340.5 (Supp. 1975) (four years from date of injury); CONN. GEN. STAT. REV. § 52-584 (Supp. 1975) (three years from date of injury); ILL. REV. STAT. ch. 83, § 22.1 (1966) (10 years after date of injury); ORE. REV. STAT. ch. 12.110(4) (1973) (five years from date of injury).

249. TEX. INS. CODE ANN. art. 5.82, § 4 (Supp. 1975). The pertinent wording of the statute is as follows:

Notwithstanding any other law, no claim against a person or hospital covered by a policy of professional liability insurance . . . whether for breach of express or implied contract or tort, for compensation for a medical treatment or hospitalization may be commenced unless the action is filed within two years of the breach or the tort complained of or from the date the medical treatment that is the subject of the claim or the hospitalization for which the claim is made is completed . . .

The new statute also changes the limitations period for malpractice actions brought by or on behalf of minors. TEX. REV. CIV. STAT. ANN. art. 5535 (Supp. 1975) provides that limitations do not begin to run for a minor's cause of action until the minor reaches his majority, a period of time potentially as long if not longer than that allowed by the discovery rule. The new statute provides that minors "under the age of six years shall

covered by professional liability insurance, apparently the case law development of the discovery rule and other exceptions to the statute of limitations would continue to apply to those persons and hospitals that do not carry professional liability insurance. This limitation on the applicability of the statute certainly raises the possibility that it might be considered unconstitutional as a denial of equal protection of the law under the fourteenth amendment.

#### DAMAGES

The measure of damages recoverable in an action by a patient against his doctor for injury resulting from the negligent treatment by the doctor is generally the same as that allowed in any other tort action: whatever is necessary to restore the plaintiff to the position he occupied prior to the occurrence of the harmful treatment including compensation for medical expenses, loss of wages, impairment of future earnings, physical and mental disability, and pain and suffering.<sup>250</sup> Obviously, much of what has been written on the subject of damages deals with the problems inherent in placing a dollar value on a physical disability or the pain that one experiences as the result of an injury.<sup>251</sup> That a tortfeasor should be required to pay for all harm proximately caused by his wrongdoing including pain has continued to be a basic premise of recovery of damages in tort.<sup>252</sup> The recent increase in medical malpractice suits<sup>253</sup> and a gradual shift in sympathies of juries from defendants to plaintiffs<sup>254</sup> has resulted in more publicity being given to increased verdicts and judgments,<sup>255</sup> and ensuing increases in medical malpractice liability insurance premiums and other medical costs.<sup>256</sup>

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have until their eighth birthday in which to file . . . such claim." TEX. INS. CODE ANN. art. 5.82, § 4 (Supp. 1975). The effect is to substantially shorten the period of time in which many minors may file or have filed for them a lawsuit against certain physicians and hospitals.

250. See generally 2 D. LOISELL & H. WILLIAMS, *MEDICAL MALPRACTICE* ¶¶ 18.01-.14, at 541-63 (1973); J. STEIN, *DAMAGES AND RECOVERY* §§ 8-29, 11-45 (1972).

251. See, e.g., MORRIS, *Liability for Pain and Suffering*, 59 COLUM. L. REV. 476 (1959); O'Connell & Simon, *Payment for Pain & Suffering: Who Wants What, When & Why?*, 1972 U. ILL. L.F. 1 (1972); Olender, *Proof and Evaluation of Pain and Suffering in Personal Injury Litigation*, 1962 DUKE L.J. 344 (1962); Plant, *Damages for Pain and Suffering*, 19 OHIO ST. L.J. 200 (1958).

252. See Peck, *Compensation for Pain: A Reappraisal in Light of New Medical Evidence*, 72 MICH. L. REV. 1355, 1355 (1974).

253. One study indicates that from 1965-69 there were 50 percent more cases appealed than from 1960-64. See Dietz, Baird, & Berul, *The Medical Malpractice Legal System*, MALPRACTICE COMMISSION REPORT, APP., at 135 (1973).

254. Keeton, *Compensation for Medical Accidents*, 121 U. PA. L. REV. 590, 615 (1973).

255. MALPRACTICE COMMISSION REPORT, at 18-19.

256. See generally Linster, *Insurance View of Malpractice*, 38 INS. COUNSEL J. 528 (1971); MORRIS, *Medical Report: Malpractice Crises—A View of Malpractice in the 1970's*, 38 INS. COUNSEL J. 521 (1971).

The medical malpractice "crisis" has caused many to rethink the present system of risk-allocation and liability in medical malpractice litigation with a view toward spreading the risks among more people and decreasing the time between the injury-causing occurrence and the receipt of compensation.<sup>257</sup> Discussion of the various suggestions in detail is beyond the scope of this paper, but it seems appropriate to mention some of the suggested alternatives in restructuring the present system of damages recovery.

One writer has suggested that while the traditional fault-liability system of recovery might be retained, the compensation for pain and suffering should be reduced.<sup>258</sup> This is based on medical research which proposes that some pain is psychologically induced, socially reinforced and is, therefore, caused more by the emotional state of the plaintiff than the wrongful act of the defendant.<sup>259</sup> It follows, then, that the defendant should be required to compensate the plaintiff only for pain which is physiologically induced by his negligence.<sup>260</sup>

A second approach has centered around the introduction of either non-fault insurance compensation paid for by individuals or a public system of social security.<sup>261</sup> Either system would have advantages in eliminating administrative costs of determining causation and in compensating all who have been injured regardless of their ability to establish fault on the part of the defendant.<sup>262</sup> Particularly in a social security system, though, the amount of individual recovery would have to be greatly reduced both for cost reasons and to discourage malingering.<sup>263</sup>

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257. For a list of objectives to be attained in formulating possible compensation systems, see Keeton, *Compensation for Medical Accidents*, 121 U. PA. L. REV. 590, 603 (1973).

258. Peck, *Compensation for Pain: A Reappraisal in Light of New Medical Evidence*, 72 MICH. L. REV. 1355, 1395 (1974).

259. The author discusses recent medical research into pain phenomena produced by social factors such as the pain an older worker feels when a younger man comes on the job or pain a housewife may feel when faced with the prospect of doing housework she despises. Such pain is termed "psychogenic" pain. *Id.* at 1360-62. The author further suggests that those people who are inclined to experience "psychogenic" pain are, in effect, looking for ways to be hurt in order to gain sympathy, and therefore, a defendant should not be held responsible for the full amount of pain felt by an injured plaintiff but only that amount directly caused by the defendant's act. *Id.* at 1389-95. The determination of causes varying the amounts of pain is to be made with the aid of psychiatric testimony. *Id.* at 1382-84.

260. *Id.* at 1396.

261. Keeton, *Compensation for Medical Accidents*, 121 U. PA. L. REV. 590, 600 (1973).

262. *Id.* at 604-10. Administrative costs, which are typical in a fault-and-liability system are those incurred in a case-by-case determination of liability and damages to be awarded. *Id.* at 609. One argument in favor of traditional negligence law is that it acts as a deterrent of dangerous antisocial conduct because of the imposition of liability for engaging in the injury-causing activity. The liability itself is the deterrent, however, and liability is present in both a fault and a nonfault system. *Id.* at 606-607.

263. *Id.* at 611. By keeping benefits awarded under a social security system or a nonfault system at a minimum for cost purposes, it is probable that beneficiaries who

A third alternative would extend the liability theories of products liability to the suppliers of consumer services, in this case, physicians.<sup>264</sup> This extension of "enterprise liability"<sup>265</sup>—a strict liability theory of recovery—to services is urged as a means of achieving a balance between the cost of accidents and the cost of avoidance,<sup>266</sup> as a method of compensating all while reducing administrative costs through reduced use of the courts,<sup>267</sup> and as an effective system of spreading the risk to all who use the services.<sup>268</sup>

Another aspect of damages recovery which has recently been subject to much criticism is the contingent fee system.<sup>269</sup> The Secretary's Commission on Medical Malpractice found that many physicians feel the contingent fee system is the root of the malpractice problem.<sup>270</sup> The normal contingent fee charged by an attorney is 33-1/3 percent of any amount recovered.<sup>271</sup>

The system has value in that it provides an opportunity for the poor to bring a meritorious claim to court.<sup>272</sup> Furthermore, it provides incentive for an attorney to produce his best work since he will not be paid or compensated for his out-of-pocket expenses if he loses.<sup>273</sup> The contingent fee system

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have sustained injuries will not be compensated for losses now labeled "pain and suffering." *Id.* at 615.

264. Comment, *Continuing the Common Law Response to the New Industrial State: The Extension of Enterprise Liability to Consumer Services*, 22 U.C.L.A. L. REV. 401 (1974).

265. Enterprise liability is an extension of tort liability which is neither based upon a finding of fault nor limited to products. Enterprise liability dictates that a defendant be held liable for all harms associated with an activity upon proof of injury by the plaintiff, but subject to exculpation by defendant's proof of non-ordinary use. . . .  
*Id.* at 403 n.8.

266. *Id.* at 433-41. For a physician, this balancing process would probably mean the use of more safety techniques in performing treatments with a resulting increase in cost. In cases involving high-risk procedures, the balancing process would mean either detailed disclosure of risks and consent from the patient, or a simple refusal to perform certain procedures. In either case, the result might be a higher level of safety.

267. *Id.* at 444-46. Obviously the introduction of strict liability into medical malpractice would encourage settlement of a claim and greatly decrease litigation processes.

268. *Id.* at 441-44. The underlying theory is that any increase in cost due to the cost of accident prevention would be evenly spread among all who request the services of the physician in question.

269. See Dietz, Baird, & Berul, *The Medical Malpractice Legal System*, MALPRACTICE COMMISSION REPORT, APP., at 113-22 (1973). See generally Schwartz & Mitchell, *An Economic Analysis of the Contingent Fee in Personal-Injury Litigation*, 22 STAN. L. REV. 1125 (1970); Note, *New Jersey's Maximum Contingent Fee Schedule: The Validity of Rule 1:21-7*, 5 RUTGERS-CAMDEN L.J. 534 (1974).

270. MALPRACTICE COMMISSION REPORT, at 32 (1973).

271. *Id.* at 32. The commission found that 33-1/3% was the most commonly used contingent fee although fees were sometimes as high as 40 and 50 percent. *Id.* at 32. Almost all personal injury litigation for plaintiffs is handled by attorneys under a contingent fee arrangement while defense lawyers usually work on an hourly fee basis.

272. Dietz, Baird, & Berul, *The Medical Malpractice Legal System*, MALPRACTICE COMMISSION REPORT, APP., at 113 (1973).

273. *Id.* at 113. See also Schwartz & Mitchell, *An Economic Analysis of the Contingent Fee in Personal-Injury Litigation*, 22 STAN. L. REV. 1125, 1125-26 (1970).

has been attacked, however, because it provides so great an opportunity for "overreaching" of a client by an attorney,<sup>274</sup> because it allows an attorney to obtain an unusually large fee when the damage recovery is large,<sup>275</sup> and because it might encourage attorneys to accept unmeritorious cases with a possibility of a large recovery or settlement.<sup>276</sup>

The Secretary's Commission on Medical Malpractice specifically found that many of these fears were groundless,<sup>277</sup> but did recommend that courts adopt rules and that states enact legislation requiring uniform contingent fee rates in which the percentage fee decreases as the recovery amount increases.<sup>278</sup> Both New York and New Jersey have adopted court rules which regulate the percentage fee which an attorney may charge as a contingent fee.<sup>279</sup> Both rules have been upheld by the highest court of each state as

274. See Note, *New Jersey's Maximum Contingent Fee Schedule: The Validity of Rule 1:21-7*, 5 RUTGERS-CAMDEN L.J. 534, 540-43 (1974).

275. Dietz, Baird, & Berul, *The Medical Malpractice Legal System*, MALPRACTICE COMMISSION REPORT, APP., at 113 (1973).

276. *Id.* at 113. Of the lawyers surveyed who represented defendants, it was found that 20% felt contingent fees encouraged frivolous claims and none felt they discouraged frivolous claims as compared with 1% and 4% of the plaintiff's lawyers, respectively. Further, 15% of defense lawyers felt contingent fees allowed the lawyer to obtain too high a fee as compared with none of the plaintiff's lawyers. *Id.* at 119. It was also found that plaintiff's lawyers had spent an average of 440 hours per case on cases for which they had received no compensation. *Id.* at 116.

277. In fact, the commission found that even some meritorious claims were rejected because the potential recovery was too low to provide adequate compensation to the attorney for the time required. *Id.* at 118. The commission also found that the average fee for a plaintiff's lawyer was approximately \$63 per hour compared with \$50 per hour for a defense lawyer. *Id.* at 115.

278. MALPRACTICE COMMISSION REPORT, at 34-35. Presently the rule in Texas and in most states is that a fee charged must not be "in excess of a reasonable fee." See State Bar of Texas, Rules and Code of Professional Responsibility, DR 2-106(A), (B) (1973). Generally attorneys are discouraged from accepting cases on a contingent fee basis if the client is able to pay a "reasonable fixed fee"; however, when the client has been informed of all "relevant factors" and when the circumstances justify entering into a contingent fee arrangement, it is not "necessarily improper" for a lawyer to do so. See State Bar of Texas, Rules and Code of Professional Responsibility, EC 2-20 (1973).

279. Compare N.Y. SUP. CT., APP. DIV., 1ST DEPT. R. 4 with R. GOVERNING CTS. OF N.J. 1:21-7. The New Jersey Court rule provides for a graduated contingent fee as follows:

1. 50% on the first \$1000 recovered;
2. 40% on the next \$2000 recovered;
3. 33 $\frac{1}{3}$ % on the next \$47,000 recovered;
4. 20% on the next \$50,000 recovered;
5. 10% on any amount recovered over \$100,000.

R. GOVERNING CTS. OF N.J. 1: 21-7(c). The New York rule has similar provisions with an alternative of a percentage fee not in excess of 33-1/3%. N.Y. SUP. CT., APP. DIV., 1ST DEPT. R. 4. The New Jersey rule allows an attorney to petition the court for payment of an additional fee if the fee determined by the rule should prove to be inadequate. R. GOVERNING CTS. OF N.J. 1: 21-7(f). The rule has been upheld by the New Jersey Supreme Court as originally written. *American Trial Lawyers v. New Jersey Supreme Ct.*, 330 A.2d 350 (N.J. 1974). It was suggested, however, that a provision might be included in the rule to allow a prelitigation determination of payment



within the authority of the rule-making body.<sup>280</sup>

A third consideration in discussing the amount of damages recoverable is the "collateral source" rule.<sup>281</sup> Generally this rule provides that benefits received by an injured party from a source independent of the wrongdoer are not admissible in evidence, and are not considered as a credit in computing the amount of damages payable by the defendant.<sup>282</sup> Despite the fact that the rule is contradictory to the general rule that a plaintiff shall be compensated for his injury only once,<sup>283</sup> the collateral source rule is accepted in almost all jurisdictions.<sup>284</sup> Reasons that have been given for the rule are that as between the parties, the plaintiff and not the defendant should benefit; collateral source benefits are a supplement to compensatory damages; generally collateral source benefits are received from sources to which the plaintiff has paid some sort of consideration; and the payment of collateral source benefits acts as an inducement to settle a case without going to trial.<sup>285</sup> The effect of the rule is punitive as to the defendant and has been justified as a deterrent to socially unacceptable behavior.<sup>286</sup> The rule

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of additional fees when the estimated time required to handle the case appears to be disproportionate to the prospective recovery and fee. Note, *New Jersey's Maximum Contingent Fee Schedule: The Validity of Rule 1:21-7*, 5 RUTGERS-CAMDEN L.J. 534, 553-55 (1974).

280. Compare *Gair v. Peck*, 188 N.Y.S.2d 491 (Ct. App. 1959), *cert. denied*, 361 U.S. 374 (1960) with *American Trial Lawyers v. New Jersey Supreme Ct.*, 330 A.2d 350 (N.J. 1974). The area of fixed fee schedules for attorneys seems to be a potential source of future litigation. The Supreme Court recently ruled that the Virginia Bar Association's minimum fee schedule for common legal services and its enforcement mechanism constituted price-fixing in violation of the Sherman Antitrust Act. It seems probable that the question will soon be raised in other jurisdictions. *Goldfarb v. Virginia State Bar*, 420 U.S. 944 (1975).

281. For discussions of the collateral source rule, see Maloney, *Collateral Source—Its Past, Present and Future*, 11 FORUM 150 (1975); Maxwell, *The Collateral Source Rule in the American Law of Damages*, 46 MINN. L. REV. 669 (1962); Mocerri & Messina, *The Collateral Source Rule in Personal Injury Litigation*, 7 GONZAGA L. REV. 310 (1972); Peckinpaugh, *An Analysis of the Collateral Source Rule*, 32 INS. COUNSEL J. 32 (1965).

282. See Peckinpaugh, *An Analysis of the Collateral Source Rule*, 32 INS. COUNSEL J. 32 (1965).

283. E.g., *White v. United States*, 507 F.2d 1101, 1103 (5th Cir. 1975); *Harrington v. Texaco, Inc.*, 339 F.2d 814, 820 (5th Cir. 1964), *cert. denied*, 380 U.S. 985 (1965); *Myers v. Isthmian Lines, Inc.*, 282 F.2d 28, 29 (1st Cir. 1960), *cert. denied*, 365 U.S. 804 (1961); *Aldrich v. Charles Beauregard & Sons*, 200 A.2d 14, 19 (N.H. 1964); *Crockett v. Housing Authority*, 274 S.W.2d 187, 190 (Tex. Civ. App.—Dallas 1954, no writ).

284. Peckinpaugh, *An Analysis of the Collateral Source Rule*, 32 INS. COUNSEL J. 32 (1965); Note, *Unreason in the Law of Damages: The Collateral Source Rule*, 77 HARV. L. REV. 741, 742 (1964).

285. *Grayson v. Williams*, 256 F.2d 61, 65 (10th Cir. 1958) (plaintiff should benefit); *Hudson v. Lazarus*, 217 F.2d 344, 346 (D.C. Cir. 1954) (benefits supplement compensatory damage); see *Perrott v. Shearer*, 17 Mich. 48, 56 (1868) (plaintiff has paid for benefit); Mocerri & Messina, *The Collateral Source Rule in Personal Injury Litigation*, 7 GONZAGA L. REV. 310, 312, 315-16 (1972); Peckinpaugh, *An Analysis of the Collateral Source Rule*, 32 INS. COUNSEL J. 32, 37-38 (1965).

286. *City of Salinas v. Souza & McCue Const. Co.*, 57 Cal. Rptr. 337, 342-43 (1967);

operates to keep evidence from the jury of gratuitous services furnished the plaintiff, insurance proceeds paid, pension or retirement benefits, wage continuation payments,<sup>287</sup> and other similar benefits so that these items will not be considered by the jury in making a determination of damages to be awarded.<sup>288</sup> The result is often a windfall to the plaintiff, and, in fairness to the defendant, the rule should be abolished.<sup>289</sup>

Finally, consideration should be given to the requirement in most jurisdictions that the plaintiff's petition state a specific amount of damage recovery sought.<sup>290</sup> The Secretary's Commission on Medical Malpractice found that the amount claimed in the *ad damnum* clause was often greatly exaggerated since a plaintiff can recover no more than the amount he requests.<sup>291</sup> The

Moceri & Messina, *The Collateral Source Rule in Personal Injury Litigation*, 7 GONZAGA L. REV. 310, 312 (1972).

287. *E.g.*, Grayson v. Williams, 256 F.2d 61, 65-66 (10th Cir. 1958) (insurance proceeds); Hudson v. Lazarus, 217 F.2d 344, 347 (D.C. Cir. 1954) (gratuitous services); Standard Oil Co. v. California, 153 F.2d 958, 963 (9th Cir. 1946), *aff'd*, 332 U.S. 301 (1947) (wage continuation payments); Price v. United States, 179 F. Supp. 309, 314 (E.D. Va. 1959), *aff'd*, 288 F.2d 448 (4th Cir. 1961) (retirement benefits); Taylor v. Jennison, 335 S.W.2d 902, 903 (Ky. 1960) (insurance proceeds); Stone v. City of Seattle, 391 P.2d 179, 183 (Wash. 1964) (pension benefits); *see* Peckinpaugh, *An Analysis of the Collateral Source Rule*, 32 INS. COUNSEL J. 32 (1965). It should be noted that, as to this collateral source, the collateral source rule may eventually disappear as more insurers include specific subrogation clauses in their policies and acceptance of such clauses becomes more widespread. *Id.* at 33.

288. Recently there has been a great deal of discussion concerning whether or not evidence of a spouse's remarriage may be introduced in evidence in a wrongful death suit. Texas has recently passed a statute allowing introduction of evidence of a spouse's "actual ceremonial remarriage" in a wrongful death action. TEX. REV. CIV. STAT. ANN. art. 4675a (Supp. 1975). In discussing this statute, the supreme court has held that the judiciary may not inquire into the effect of such evidence on the fact finder, implying that the evidence may be introduced in mitigation of damages. Exxon Corp. v. Brecheen, 526 S.W.2d 519, 525 (Tex.), *rev'g*, 519 S.W.2d 170 (Tex. Civ. App.—Houston [1st Dist.] 1975). *But see* Richardson v. Holmes, 525 S.W.2d 293, 299 (Tex. Civ. App.—Beaumont 1975, writ *ref'd n.r.e.*) (allowing introduction of evidence of remarriage but not for the purpose of diminishing damages recoverable). For discussions of this question, *see* Shields & Giles, *Remarriage and the Collateral Source Rule*, 36 INS. COUNSEL J. 354 (1969); Comment, *Remarriage and the Illinois Wrongful Death Act: The Effect of Changes in Status of Beneficiaries on Damages in Wrongful Death Actions*, 7 JOHN MARSHALL J. 395 (1975).

289. Peckinpaugh, *An Analysis of the Collateral Source Rule*, 32 INS. COUNSEL J. 32, 39-40 (1965). *Contra*, Moceri & Messina, *The Collateral Source Rule in Personal Injury Litigation*, 7 GONZAGA L. REV. 310, 327-28 (1972). Perhaps the strongest argument in favor of continuation of the rule is that the defendant should not be allowed to benefit from the plaintiff's foresight in purchasing insurance of one kind or another. In view of the increasingly larger verdicts for damages, though, it would seem that public policy would argue for spreading the risk through the use of insurance rather than placing the entire burden on the defendant's shoulders. The amount of insurance premiums paid could be considered part of the damage incurred by the plaintiff.

290. MALPRACTICE COMMISSION REPORT, at 37-38; Bradford, *How to Talk Dollars and Cents to the Jury*, 1959 INS. L.J. 567, 567 (1959).

291. MALPRACTICE COMMISSION REPORT, at 38. Under TEX. R. CIV. P. 301 a judgment must conform to "the pleadings, the nature of the case proved and the verdict."

result is an unnecessary source of hostility between the legal and medical professions and media publicity given to a distorted amount of damages claimed.<sup>292</sup> The committee recommended that the dollar amount in the *ad damnum* clause be eliminated.<sup>293</sup> The Medical Professional Liability Study Commission of Texas has also voted to recommend elimination of a specific dollar amount from the *ad damnum* clause in pleadings in Texas in favor of allowing the plaintiff to plead for "such damages as plaintiff is entitled to under the law and the evidence."<sup>294</sup>

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Consequently if a judgment is rendered in an amount in excess of that pleaded, it is an erroneous judgment even though it is consistent with the jury's verdict. *Socony-Vacuum Oil Co. v. Aderhold*, 150 Tex. 292, 300, 240 S.W.2d 751, 756 (1951); *Biscayne Texas Properties v. Miner*, 502 S.W.2d 225, 228 (Tex. Civ. App.—El Paso 1973, writ ref'd n.r.e.). Generally the plaintiff pleads for recovery of a specific dollar amount, but recovery has been allowed where the amount of damages alleged is less specific and the pleadings were not objected to as indefinite. *City of Wichita Falls v. Dye*, 517 S.W.2d 680, 682 (Tex. Civ. App.—Fort Worth 1974, writ ref'd n.r.e.) (upholding \$1,007.50 award where prayer for relief was for "at least \$900"). *But see White v. Jackson*, 358 S.W.2d 174, 179 (Tex. Civ. App.—Waco 1962, writ ref'd n.r.e.) (reversing a default judgment wherein plaintiff's petition alleged actual damage in an amount greatly in excess of \$1,000).

292. MALPRACTICE COMMISSION REPORT, at 38. Of 2,784 claims against members of the California Hospital Association between 1969-1972, it was found that the damages requested were 53 times greater than those actually recovered. *Id.* at 38 n.19.

293. *Id.* at 38.

294. Keeton, *Introduction, Medical Malpractice in Texas*, 7 ST. MARY'S L.J. 733, 734 (1976).